



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Wadley Regional Medical Center

Respondent Name

Hartford Underwriters Insurance Co

MFDR Tracking Number

M4-21-0111-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

September 22, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above reference patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: \$238.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dates of service in dispute were processed in accordance with Texas Workers' Compensation Guidelines, 28 TAC §134.403 (f), §134.203 (c)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 14 – 19, 2020	Outpatient Hospital Services	\$238.87	\$238.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 3250 – Reimbursement is based on the OSR contracted amount

- 4097 – Paid per fee schedule charge adjusted because statute dictates allowance is greater than provider’s charge
- QP12 – Workers’ compensation jurisdictional fee schedule adjustment

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount \$238.57 for outpatient hospital services rendered in May 2020. The insurance carrier reduced the disputed services based on bundling and workers compensation fee schedule, contract rate and allowance greater than provider’s charge.

28 §134.403 (e) states in pertinent part **regardless** of billed amount, reimbursement shall be the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011 or if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section. Insufficient evidence was found to support a contract exists. The MAR calculation is discussed below.

28 TAC §134.403 (d) requires Texas workers’ compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

28 TAC 134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.. The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent when a separate request for implant reimbursement is not made and 108 percent when separate reimbursement for implants is made.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code C1713 has status indicator N for packaged codes payment is included in primary services.
- Procedure code 36415, billed May 14, 2020, has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
- Procedure code 80053, billed May 14, 2020, has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
- Procedure code 85025, billed May 14, 2020, has status indicator Q4 for packaged labs reimbursement is included with payment for the primary services.
- Procedure code 71046 has status indicator Q3. This code is packaged in comprehensive J1 code 23430
- Procedure code 23430 has status indicator J1 and a ranking of 396 the highest for this date of service. The Medicare Claims Processing Manual at www.cms.gov states in pertinent part, *When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service.*

This code is assigned APC 5114. The OPPS Addendum A rate is \$5,981.95. This is multiplied by 60% for an unadjusted labor amount of \$3,589.17, in turn multiplied by facility wage index 0.8457 for an adjusted labor amount of \$3,035.36.

The non-labor portion is 40% of the APC rate, or \$2,392.78.

The sum of the labor and non-labor portions is \$5,428.14.

The Medicare facility specific amount is \$5,428.14.

This is multiplied by 200% for a MAR of \$10,856.28.

- Procedure code 29823 has a status indicator of J1 and a ranking of 1,612. This is not the highest ranking comprehensive code so is packaged into code 23430.
 - Procedure code 29824 has a status indicator of J1 and a ranking of 1,614. This is not the highest ranking comprehensive code so is packaged into code 23430.
 - Procedure code J0171 has status indicator N reimbursement is packaged with payment for the primary services.
 - Procedure code J0330 has status indicator N reimbursement is packaged with payment for the primary services.
 - Procedure code J0690 has status indicator N reimbursement is packaged with payment for the primary services.
 - Procedure code J1100 has status indicator N reimbursement is packaged with payment for the primary services.
 - Procedure code J1644 has status indicator N reimbursement is packaged with payment for the primary services.
 - Procedure code J2250 has status indicator N reimbursement is packaged with payment for the primary services.
 - Procedure code J2710 has status indicator N reimbursement is packaged with payment for the primary services.
 - Procedure code J3010 has status indicator N reimbursement is packaged with payment for the primary services.
2. The total recommended reimbursement for the disputed services is \$10,856.28. The insurance carrier paid \$10,580.49. The requestor is seeking additional reimbursement of \$238.87. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is \$238.87.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor \$238.87, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 15, 2020
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.