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**
North American Specialty Insurance

**MFDR Tracking Number**
M4-21-0173-01

**Carrier's Austin Representative**
Box Number 48

**MFDR Date Received**
October 2, 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 34.404 of Texas Administrative Code."

**Amount in Dispute:** $428.07

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** The Austin carrier representative for North American Specialty Insurance is Arthur J Gallagher & Co who was notified of this medical fee dispute on October 6, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| April 17, 2020 | Outpatient Hospital Services | $428.07 | $428.07 |

## *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**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
    - 45 – Charge exceeds fee schedule /maximum allowable or contracted/legislated fee arrangement

- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 5162 – Your discount is taken in accordance with your PPO contract arrangement with Corporate Remedies
- 3411 – The sole community hospital or essential access hospital payment adjustment has been applied

**Issues**

1. Did the respondent support the contract reduction?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking additional reimbursement in the amount $428.07 for outpatient hospital services rendered on April 17, 2020. The insurance carrier reduced the disputed services based on PPO discount. Review of the submitted information found insufficient evidence the injured worker was enrolled in a PPO. This reduction is not supported. The services in dispute will be reviewed per applicable fee guideline.

2. 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 130 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 73721 RT, LT have a status indicator Q3, for packaged codes paid through a composite APC. The payment for composite services is calculated below.
   - The composite APC 8007 for MRI without contrast has an allowable of $543.18. The APC payment multiplied by 60% equals $325.91 which in turn is multiplied by the facility wage index of 0.8547 equals $275.62.

     The APC payment is multiplied by 40% which equals $217.28 for non-labor portion.

     The sum of the labor and non-labor portion equals the Medicare facility specific payment of $492.89.

     This amount is multiplied by 200% or $985.78.

The recommended reimbursement for the disputed services is $985.78. The insurance carrier paid $554.36. The requestor is seeking additional reimbursement of $428.07. 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 $428.07.

## *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 $428.07, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

| Signature | Medical Fee Dispute Resolution Officer | April 28, 2021<br>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**.