TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Knapp Medical Center

Respondent Name
Weslaco ISD

MFDR Tracking Number
M4-21-0959-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
February 22, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB invoice denied due to the service is considered bundled into another service. In accordance with the TX WC fee schedule expected reimbursement for services rendered is $178.51."

Amount in Dispute: $178.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Weslaco ISD is Dean Pappas who was notified of this medical fee dispute on March 2, 2021. 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
July 31 – August 3, 2020	Outpatient Hospital Services	$178.51	$178.51

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:

- 97 – The benefit for this service is included in the payment / allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule.

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 $178.51 for outpatient hospital services rendered in July and August 2020. The insurance carrier reduced the disputed services based on workers' compensation fee schedule and bundled services.

   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 36415, billed July 31, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code C9803, billed July 31, 2020, has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. Review of the submitted medical bill found no codes with a status indicator of S,T or V were submitted. The insurance carriers' denial is not supported. This code is separately reimbursed.

     This code is assigned APC 5731. The OPPS Addendum A rate is $22.99. This is multiplied by 60% for an unadjusted labor amount of $13.79, in turn multiplied by facility wage index 0.8433 for an adjusted labor amount of $11.63.

     The non-labor portion is 40% of the APC rate, or $9.20.

     The sum of the labor and non-labor portions is $20.83.

     The Medicare facility specific amount is $20.83which is multiplied by 200% for a MAR of $41.66.
   - Procedure code 80048, billed July 31, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.

- Procedure code 82962 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 85025, billed July 31, 2020, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code U0003, billed July 31, 2020, has status indicator A, for services paid by fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the code on the date provided. Per DWC Professional Fee Guideline, Rule §134.203(e)(1), the facility fee is based on Medicare's Clinical Laboratory fee for this code of $100.00. 125% of this amount is $125.00. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $100.00. The lesser amount is $100.00.
- Procedure code J0690 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J3490 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J7060 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code J7120 has status indicator N, for packaged codes integral to the total service package with no separate payment.
- Procedure code 93005, billed July 31, 2020, has status indicator Q1 as no other codes with a status indicator of S, T, or V were billed, this line is separately payable. The insurance carriers' denial is not supported.

  This code is assigned APC 5733. The OPPS Addendum A rate is $55.01. This is multiplied by 60% for an unadjusted labor amount of $33.01, in turn multiplied by facility wage index 0.8433 for an adjusted labor amount of $27.84.

  The non-labor portion is 40% of the APC rate, or $22.00.

  The sum of the labor and non-labor portions is $49.84.

  The Medicare facility specific amount is $49.84 which is multiplied by 200% for a MAR of $99.68.

The total recommended reimbursement for the disputed services is $241.34. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $178.51. 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/has not established payment is due. As a result, the amount ordered is $178.51.

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 $178.51, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 16, 2021
Signature	Medical Fee Dispute Resolution Officer	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.