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
Arise Healthcare System

MFDR Tracking Number
M4-19-2000-01

MFDR Date Received
December 7, 2018

Respondent Name
Travelers Casualty Ins Co of America

Carrier's Austin Representative
Box Number 5

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Medicare Guidelines cpt code 20680 and 64445 are both reimbursable, Travelers is stating the code 64445 is a packaged code after review we show that to be incorrect."

Amount in Dispute: $535.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The reimbursement reflected on the Table of Disputed Services is the full reimbursement for the entire procedure. The Provider is not entitled to the reimbursement sought in the Table of Disputed Services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 11, 2018	Outpatient Hospital Services	$535.68	$0.00

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 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
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the requestor's position statement supported?

Findings

1. The requestor states in their position statement, "Per Medicare Guidelines cpt code 20680 and 64445 are both reimbursable."

   28 Texas Administrative Code §134.403 (d) states in pertinent part,

   For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   Review of the applicable Medicare payment policy found in Addendum B which is posted quarterly to the OPPS website and is a "snapshot" of HCPCS codes, their status indicators, APC groups, and OPPS payment rates, that are in effect at the beginning of each quarter found:

   - Procedure code 20680 has status indicator Q2, Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T". This service is packaged with code 64445 which has a status indicator "T."
   - Procedure code 64445 has status indicator "T" and is assigned APC 5442. The OPPS Addendum A rate is $543.88, multiplied by 60% for an unadjusted labor amount of $326.03, in turn multiplied by the facility wage index of 0.9764 for an adjusted labor amount of $318.34. The non-labor portion is 40% of the APC rate, or $217.35. The sum of the labor and non-labor portions is $535.69. The Medicare facility specific amount of $535.69 is multiplied by 200% for a MAR of $1,071.38.

The requestor's position statement is not supported. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 4, 2019
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 the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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 Texas Administrative Code §141.1(d).

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