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
Texas Health of HEB

Respondent Name
United States Fire Insurance Co

MFDR Tracking Number
M4-17-1534-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
January 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health of HEB to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the new fee schedule that took effect in March of 2008 for this outpatient surgery."

Amount in Dispute: $5,145.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been made in the amount of 3529.17. We are attaching the pay history and EOB."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24 – 26, 2016	Outpatient Hospital Services	$5,145.33	$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 acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS COMPENSATION JURISDICATIONAL FEE SCHEDULE ADJUSTMENT
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED

Issues

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

Findings

1. This dispute regards outpatient hospital services with reimbursement subject to the division's *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) be calculated using the Medicare facility specific amount (including outlier payments) as determined by the applicable Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors, published annually in the Federal Register, with modifications as set forth in the rules.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code J7120 is packaged into J1 procedure code 27822.
   - Procedure code A4306 is packaged into J1 procedure code 27822.
   - Procedure code C1755 is packaged into J1 procedure code 27822.
   - Procedure code L4386 is packaged into J1 procedure code 27822.
   - Procedure code C1713 is packaged into J1 procedure code 27822.
   - Procedure code 36415 is packaged into J1 procedure code 27822.
   - Procedure code 80053 is packaged into J1 procedure code 27822.
   - Procedure code 73600 is packaged into J1 procedure code 27822.
   - Procedure code 27822 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This is assigned APC 5123. The OPPS Addendum A rate is $4,969.26.

     This is multiplied by 60% for an unadjusted labor-related amount of $2,981.56,

     Multiplied by the facility wage index of 0.9572 for an adjusted labor amount of $2,853.95.

     The non-labor related portion is 40% of the APC rate, or $1,987.70.

     The sum of the labor and non-labor portions is $4,841.65.

     The Medicare facility specific amount of $4,841.65 is multiplied by 200% for a MAR of $9,683.30.
   - Procedure code 27829 is packaged into J1 procedure code 27822.
   - Procedure code 64445 is packaged into J1 procedure code 27822.
   - Procedure code 64447 is packaged into J1 procedure code 27822.
   - Procedure code G8978 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.

- Procedure code G8979 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Procedure code G8980 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Procedure code 97001 is packaged into J1 procedure code 27822.
- Procedure code J1100 is packaged into J1 procedure code 27822.
- Procedure code J1170 is packaged into J1 procedure code 27822.
- Procedure code J1200 is packaged into J1 procedure code 27822.
- Procedure code J2175 is packaged into J1 procedure code 27822.
- Procedure code J2250 is packaged into J1 procedure code 27822.
- Procedure code J2795 is packaged into J1 procedure code 27822.
- Procedure code J3010 is packaged into J1 procedure code 27822.
- Procedure code J3370 is packaged into J1 procedure code 27822..

2. The total recommended reimbursement for the disputed services is $9,683.30. The insurance carrier has paid $10,401.21 leaving an amount due to the requestor of $0.00. Additional payment is not 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

		February 10, 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 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.