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 Fort Worth

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-17-2941-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.403 section E all HCPC's that are paid per the fee schedule should pay per the APC allowable at 200% regardless of the billed charges..."

Amount in Dispute: $1,218.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2016	G0390	$1,218.57	$1,218.57

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 services in an outpatient facility.
3. The insurance carrier reduced 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

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What Division rule is applicable to the reimbursement of outpatient services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement of $1,218.57 for outpatient hospital services rendered on June 17, 2016.

   The requestor states, "…HCPC's that are paid per the fee schedule should pay per the APC allowable at 200% regardless of the billed charges." The respondent states, "…the carrier asserts that it has paid according to applicable fee guidelines…"

   As both positions are related to the appropriate fee, this review will consider the applicable fee guideline found in 28 Texas Administrative Code §134.403, "Hospital Facility Fee Guideline--Outpatient."

   The relevant portions are:

   > (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise
   >
   > > (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > (d) 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 with any additions or exceptions specified in this section, including the following paragraphs.
   >
   > (f) 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 following minimal modifications shall be applied.
   >
   > > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > >
   > > (A) 200 percent; unless
   > >
   > > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

2. The Medicare payment policies used to calculate the MAR are found at, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are found below:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Review of the submitted medical claim finds no request for separate reimbursement of implantables. The services in dispute will be reviewed per 28 Texas Administrative Code § 134.403 (f)(1)(A).

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.9572	40% non-labor related	Payment	Maximum allowable reimbursement
G0390	V	5045	$851.40	$851.40 x 60% = $510.814	$510.814 x 0.9572 = $488.98	$851.40 x 40% = $340.56	$488.98 + $340.56 = $829.54	$829.54 x 200% = $1,659.08
						Total		$1,659.08

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

> Regardless of billed amount, reimbursement shall be:
>
> (1) 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

The health care provider submitted a charge of $440.50 but per the requirements shown above the maximum allowable reimbursement was calculated per the applicable fee schedule.

3. The total recommended reimbursement for the disputed service is $1,659.08. The insurance carrier has paid $440.50 leaving an amount due to the requestor of $1,218.58. The requestor is seeking $1,218.57. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,218.57.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,218.57, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		July 26, 2017
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.