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
City of Fort Worth

MFDR Tracking Number
M4-18-0825-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
November 28, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There is still an underpayment to that is due for this code in the amount of $276.55."

Amount in Dispute: $276.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged December 5, 2017. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2017	Outpatient Hospital Services	$276.55	$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:
   - 16 – Claim/service lacks information which is needed for adjudication.

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
- 193 – Original payment decision is being maintained. upon review it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. Is additional reimbursement due?

Findings

1. The requestor is seeking additional reimbursement for outpatient emergency room services rendered on March 3, 2017 in the amount of $276.55. The insurance carrier reduced the disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.403 (f) (1) (A) (B) 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 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.

Review of the submitted medical claim finds implantables were not requested. The service in dispute will be reviewed per 28 Texas Administrative Code §134.403 (f) (1) (A).The maximum allowable reimbursement (MAR) is calculated below.

- Procedure code 71010 has status indicator Q3, denoting conditionally packaged codes paid as a composite if OPPS criteria are met. As packaging criteria were not met, this line is separate. This is assigned APC 5521. The OPPS Addendum A rate is $59.86, which is multiplied by 60% for an unadjusted labor-related amount of $35.92, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $34.55. The non-labor related portion is 40% of the APC rate, or $23.94. The sum of the labor and non-labor portions is $58.49. The Medicare facility specific amount of $58.49 is multiplied by 200% for a MAR of $116.98.
- Procedure code 73552 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 72125 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). This service is assigned to composite APC 8005. This service qualifies for composite payment. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. If a composite includes multiple lines, the charges for those combined services are summed to one line. The payment for composite services is calculated below.
- Procedure code 70450 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). This service is assigned to composite APC 8005. This service qualifies for composite payment. Codes assigned to composites are major components of a single episode of care;

the hospital receives one payment for any combination of designated procedures. If a composite includes multiple lines, the charges for those combined services are summed to one line. The payment for composite services is calculated below.

- Procedure code 12001 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 96374 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5693. The OPPS Addendum A rate is $179.77, which is multiplied by 60% for an unadjusted labor-related amount of $107.86, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $103.74. The non-labor related portion is 40% of the APC rate, or $71.91. The sum of the labor and non-labor portions is $175.65. The Medicare facility specific amount of $175.65 is multiplied by 200% for a MAR of $351.30.
- Procedure code 96375 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5691. The OPPS Addendum A rate is $34.78, which is multiplied by 60% for an unadjusted labor-related amount of $20.87, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $20.07. The non-labor related portion is 40% of the APC rate, or $13.91. The sum of the labor and non-labor portions is $33.98. The Medicare facility specific amount of $33.98 is multiplied by 200% for a MAR of $67.96.
- Procedure code 99285 has status indicator J2, Comprehensive APC payment based on OPPS comprehensive-specific payment criteria if comprehensive payment criteria is met. As the criteria is not met, this is assigned APC 5025. The OPPS Addendum A rate is $488.74, which is multiplied by 60% for an unadjusted labor-related amount of $293.24, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $282.04. The non-labor related portion is 40% of the APC rate, or $195.50. The sum of the labor and non-labor portions is $477.54. The Medicare facility specific amount of $477.54 is multiplied by 200% for a MAR of $955.08.
- Procedure code 90715 has status indicator N, denoting packaged codes integral to the total service no separate payment.
- Procedure code J2270 has status indicator N, denoting packaged codes integral to the total service no separate payment.
- Procedure code J2405 has status indicator N, denoting packaged codes integral to the total service no separate payment.
- Procedure code G0390 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5045. The OPPS Addendum A rate is $872.07, which is multiplied by 60% for an unadjusted labor-related amount of $523.24, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $503.25. The non-labor related portion is 40% of the APC rate, or $348.83. The sum of the labor and non-labor portions is $852.08. The Medicare facility specific amount of $852.08 is multiplied by 200% for a MAR of $1,704.16.
- Procedure code 90471 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5692. The OPPS Addendum A rate is $53.17, which is multiplied by 60% for an unadjusted labor-related amount of $31.90, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $30.68. The non-labor related portion is 40% of the APC rate, or $21.27. The sum of the labor and non-labor portions is $51.95. The Medicare facility specific amount of $51.95 is multiplied by 200% for a MAR of $103.90.
- Procedure codes 72125, and 70450 have status indicator Q3, denoting packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8005, for computed tomography (CT) services without contrast.

This is assigned APC 8005. The OPPS Addendum A rate is $273.09, which is multiplied by 60% for an unadjusted labor-related amount of $163.85, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $157.59. The non-labor related portion is 40% of the APC rate, or $109.24. The sum of the labor and non-labor portions is $266.83. The Medicare facility specific amount of $266.83 is multiplied by 200% for a MAR of $533.66.

2. The total recommended reimbursement for the disputed services is $3,833.04. The insurance carrier has paid $3,832.84. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

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 15, 2018
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.