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
TX HEALTH OF STEPHENVILE

Respondent Name
TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

MFDR Tracking Number
M4-18-1462-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
January 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit you have not paid what we determine is the correct allowable . . . for this outpatient procedure. . . . 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: $42.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement for the disputed services was properly calculated under the applicable Division-adopted fee schedule."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 17, 2017	Outpatient Hospital Services – MRI, 73721-LT	$42.05	$42.05

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 hospital fee guidelines for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional payment made on appeal/reconsideration.
   - 947 – Upheld. No additional allowance has been recommended

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   Rule §134.403(f)(1) requires that, for these services, the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure code and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 73721 has status indicator Q3, denoting codes paid as a composite package if OPPS criteria are met. As no other charges were billed, criteria are not met and this line is paid separately. This service is assigned APC 5523 with status S, indicating significant outpatient procedures paid by APC, not subject to payment reduction. The OPPS Addendum A rate for this service is $225.91. This is multiplied by 60% for an unadjusted labor-related amount of $135.55, which is multiplied by the facility wage index of 0.9318 for an adjusted labor amount of $126.31. The non-labor portion is 40% of the APC rate, or $90.36. The sum of the labor and non-labor portions is $216.67. The cost does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0. The Medicare facility specific amount of $216.67 is multiplied by 200% for a MAR of $433.34.
2. The total recommended payment for the services in dispute is $433.34. The amount previously paid by the insurance carrier is $391.28, which leaves an amount due to the requestor of $42.06. The requestor is seeking $42.05. This amount 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 available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 $42.05.

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 $42.05, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	February 9, 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.