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
HARRIS METHODIST FORT WORTH

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-18-2032

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: $582.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Prime Health Services has confirmed that the provider is par in the PHS PPO network for 85% of billed charges or 95% state fee schedule… This bill was processed correctly per the contracted rate."

Response Submitted by: Mitchell International, Inc. on behalf of Service Lloyds Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 26, 2017	Outpatient Hospital Services	$582.42	$582.42

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 facility fee guideline for outpatient services.
3. Insurance Code §1305.051 requires certification of workers' compensation health care networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 616 – THIS CODE HAS STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.
   - 617 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 97 – 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.
   - PP1 – PRICING APPLIED VIA PRIME HEALTH SERVICES. FOR INQUIRIES, PLEASE CONTACT 866-348-3887.

Issues

1. Are the disputed services subject to the provisions of a workers' compensation certified health care network?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced payment for disputed services with claim adjustment code:

   - PP1 – Pricing applied via Prime Health Services. For inquiries, please contact 866-348-3887.

   The respondent states that "Prime Health Services has confirmed that the provider is par in the PHS PPO network for 85% of billed charges or 95% state fee schedule… This bill was processed correctly per the contracted rate."

   Insurance Code Chapter 1305 sets out requirements for delivery of health care services to injured employees by networks contracting with workers' compensation insurance carriers. Insurance Code §1305.051(a) requires that "A person may not operate a workers' compensation health care network in this state unless the person holds a certificate issued under this chapter and rules adopted by the commissioner." Subsection (b) further requires that "A person may not perform any act of a workers' compensation health care network except in accordance with the specific authorization of this chapter or rules adopted by the commissioner."

   Based on information known to the division, the injured employee was not enrolled in a workers' compensation health care network (HCN) certified in accordance with Insurance Code chapter 1305 on the date of injury and the injured employee's compensation claim is not subject to reimbursement under a workers' compensation HCN contract or the provisions of Insurance Code chapter 1305. Consequently, the disputed services will be reviewed for payment in accordance with the Texas Labor Code and rules of the Division of Workers' Compensation.

2. This dispute regards outpatient facility services subject to DWC's Hospital Facility Fee Guideline, Rule §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors published in the Federal Register, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for these disputed facility services.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with 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 64450 is assigned APC 5442. The OPPS Addendum A rate is $507.19. This is multiplied by 60% for an unadjusted labor amount of $304.31, which is in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $292.69. The non-labor portion is 40% of the APC rate, or $202.88. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $495.57. This is multiplied by 200% for a MAR of $991.14.
   - Procedure code 99283 is assigned APC 5023. The OPPS Addendum A rate is $201.25. This is multiplied by 60% for an unadjusted labor amount of $120.75, which is in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $116.14. The non-labor portion is 40% of the APC rate, or $80.50. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $196.64. This is multiplied by 200% for a MAR of $393.28.
   - Procedure code 90471 is assigned APC 5692. The OPPS Addendum A rate is $53.17. This is multiplied by 60% for an unadjusted labor amount of $31.90, which is in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $30.68. The non-labor portion is 40% of the APC rate, or $21.27. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $51.95. This is multiplied by 200% for a MAR of $103.90.

   The total recommended reimbursement for the disputed services is $1,488.32. The insurance carrier paid $900.29. The requestor is seeking additional reimbursement of $582.42. 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 emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available 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 $582.42.

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 $582.42, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 22, 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.

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 form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.