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 Alliance

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-18-3603-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $311.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Initially Texas Mutual pad $220.29 for code 70450 and $220.29 for code 72125. The total payment for both codes made by Texas Mutual is $440.58. For this reason Texas Mutual believes no further payment is due code 70450."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2, 2017	Outpatient Hospital Services	$311.37	$93.08

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 jurisdictional fee schedule adjustment
   - 370 – This hospital outpatient allowance was calculated according to the apc rate, plus a markup
   - 767 – Paid per O/P FG at 200%; implants not applicable or separate reimbursement (with cert) not requested per rule 134.403(G)

Issues

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

Findings

1. The requestor is seeking $311.37 for outpatient hospital services rendered on August 2, 2017. The insurance carrier states in their position statement, "The Addendum A shows the payment amount is $273.09 for APC 8005."

   28 Texas Administrative Code §134.403 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) provider specific formulas and Addendums A and B found at www.cms.gov.

   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 implants are provided and requested. In this dispute implants were not provided or requested. The reimbursement for the disputed services is calculated as follows:

   - 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 code is assigned APC 8005. The OPPS Addendum A rate is $273.09. This is multiplied by 60% for an unadjusted labor-related amount of $163.85, which is 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 allowable reimbursement for the disputed services is $533.66. The carrier's position is not supported. A remaining balance of $93.08 is due to the requestor.

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 $93.08.

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 $93.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 19, 2018 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.