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
Texas Health Fort Worth

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-18-3673-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that 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: $84.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant is in a certified health care network… The provider is not entitled to relief under Division rule 133.305 and 133.307 as previously identified above. The carrier has preciously reimbursed the provider the amount of $5,112.10."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26-27, 2018	Outpatient Hospital Services	$84.76	$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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 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. Did the respondent support their position statement?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "The claimant is in a certified health care network. That network is Texas HCN Coventry.

   The respondent did not provide convincing evidence that the injured employee is enrolled in this network, and the carrier did not provide documentation to support that the requestor is contracted with Texas HCN Coventry.

   The Division concludes that the carrier failed to support its position statement. Therefore, the service in dispute will be reviewed per applicable Division fee guideline.

2. The requestor is seeking $84.76 for outpatient hospital services rendered on January 26 – 27, 2018. The insurance carrier reduced the disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment." The applicable fee guideline is found in 28 TAC §134.403 (d) which states in pertinent part,

   > 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

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4. The application of this payment policy in conjunction with the Division fee guideline is discussed below.

3. 28 TAC §134.403, (f) states,

   > 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 medical bill finds separate payment for implants was not requested. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) and Status Indicator for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. 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 Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates and Status Indicators in the OPPS final rules, available from www.cms.gov.

   The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure code 71045 has status indicator Q3. This code is packaged in the allowable of code 99285 with the J2 status indicator under composite APC 8011. No separate reimbursement is recommended.
   - Procedure code 99285 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). The requirements for comprehensive packaging is met. This code

is assigned APC 8011. The OPPS Addendum A rate is $2,349.82, multiplied by 60% for an unadjusted labor amount of $1,409.89, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $1,358.57. The non-labor portion is 40% of the APC rate, or $939.93. The sum of the labor and non-labor portions is $2,298.50. The Medicare facility specific amount of $2,298.50 is multiplied by 200% for a MAR of $4,597.00.

The total recommended reimbursement for the disputed services is $4,597.00. The insurance carrier paid $5,112.10. Additional payment is not recommended.

Conclusion

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

Signature	Medical Fee Dispute Resolution Officer	December 12, 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.