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
TX HEALTH ARLINGTON

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-18-3823-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
June 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT codes 96374 and 96375 both codes have a status indicator of S and are paid under OPPS with separate APC payment rates."

Amount in Dispute: $128.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reimbursed the Provider consistent with the relevant Division-adopted fee schedule."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 22, 2017	Outpatient Hospital Services	$128.23	$128.23

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 facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support this level of service.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
   - 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED
   - 4097 - PAID PER FEE SCHEDULE; CHARGE ADJUSTED BECAUSE STATUTE DICTATES ALLOWANCE IS GREATER THAN PROVIDER'S CHARGE.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code:
   - 150 – Payer deems the information submitted does not support this level of service.

   Review of the submitted medical records finds that the disputed services are supported as billed. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed for reimbursement in accordance with applicable division rules and fee guidelines.
2. This dispute regards outpatient 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 Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set out in the rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200 percent for the disputed emergency room visit 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 73130 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for other services assigned status indicator S billed for the same visit.
   - Procedure code 96374 has status indicator S for significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $179.77, multiplied by 60% for an unadjusted labor amount of $107.86, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $103.93. The non-labor portion is 40% of the APC rate, or $71.91. The sum of the labor and non-labor portions is $175.84. This amount is multiplied by 200% for a MAR of $351.68.
   - Procedure code 96375 has status indicator S for significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $34.78, multiplied by 60% for an unadjusted labor amount of $20.87, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $20.11. The non-labor portion is 40% of the APC rate, or $13.91. The sum of the labor and non-labor portions is $34.02 multiplied by 3 units is $102.06. This amount is multiplied by 200% for a MAR of $204.12.
   - Procedure code 99284 has status indicator J2, denoting an outpatient visit. This code is assigned APC 5024. The OPPS Addendum A rate is $332.41, multiplied by 60% for an unadjusted labor amount of $199.45, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $192.19. The non-labor portion is 40% of the APC rate, or $132.96. The sum of the labor and non-labor portions is $325.15. This amount is multiplied by 200% for a MAR of $650.30.
   - Procedure codes J0690, J1170, J2270 and J2405 have status indicator N, denoting packaged codes with no separate payment; reimbursement is included with payment for the primary services.
3. The total recommended reimbursement for the disputed services is $1,206.10. The insurance carrier paid $1,072.78. The requestor is seeking additional reimbursement of $128.23. This amount is recommended.

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 $128.23.

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 $128.23, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 13, 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.

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 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.