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 Alliance

Respondent Name
Starr Indemnity & Liability Co

MFDR Tracking Number
M4-18-3889-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 11, 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: $372.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It remains the carrier's position that the provider is not entitled to any reimbursement beyond what the carrier has already paid the provider."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 19, 2018	96374	$372.67	$372.67

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:
   - 137 – (97) payment is included in the allowance for another service/procedure

Issues

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

Findings

1. The requestor is seeking $372.67 for code 96374 rendered during an outpatient hospital encounter for the billed date of April 9, 2018. The insurance carrier reduced/denied payment for disputed services with claim adjustment reason code 137 – "(97) Payment is included in the allowance for another service/procedure."

   28 Texas Administrative Code §134.403 (d) 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 is outlined at www.cms.gov, the Medicare Claims Processing Manual, Chapter 4, Section 10.1.1 which states in pertinent part,

   > *An OPPS payment status indicator is assigned to every HCPCS code. 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 status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule.*

   Review of the April 2018, Addendum B pricing file finds the code in dispute has a status indicator of "S" which is defined as, "Paid under OPPS; separate APC payment." As the status indicator for this code is separately payable and no composite or comprehensive codes were submitted on the same billed date, the carrier's denial is not supported and the service in dispute will be reimbursed per applicable fee guideline.

2. 28 Texas Administrative Code §134.403 (e) requires regardless of the billed amount, the Maximum Allowable Reimbursement (MAR) is determined by Rule §134.403(f)(1) which states in pertinent part,

   > 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;

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 96374 has status indicator S. This code is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $110.48. The non-labor portion is 40% of the APC rate, or $76.44. The Medicare facility specific amount of $186.92 is multiplied by 200% for a MAR of $373.84.

3. The total recommended payment for the services in dispute is $373.84. The requestor is seeking 372.67, 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 $372.67.

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 $372.67, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 6, 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.