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 Fort Worth

Respondent Name
Argonaut Midwest Insurance Co

MFDR Tracking Number
M4-18-3991-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found this claim to be underpaid according the fee schedule as detailed in Rule 134.403 ..."

Amount in Dispute: $946.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Respondent is currently in the process of issuing the additional $9.02 payment to Requestor, which combined with the previous payments equals a total payment to Requestor of $2,379.03."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 27, 2017	Outpatient Hospital Services	$946.01	$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 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
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - 193 - Original payment decision is being maintained. Upon review, it was determined that this calim was processed properly.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $946.01 for outpatient hospital services rendered on July 27, 2017. The insurance carrier reduced/denied payment for disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment" and 618 – "The value of this procedure is packaged into the payment of other services performed on the same date of service."

   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 applicable Medicare payment policy is found in the Medicare Claims Processing Manual, Chapter Four in the following sections;

   > *10.1.1 - Payment Status Indicators*
   >
   > *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.*
   >
   > *10.2 - APC Payment Groups*
   >
   > *Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC.*
   >
   > *Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim* ***is packaged into payment for the primary service****. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.*
   >
   > > *HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of HCPCS codes designated with status indicator J1.*

   The applicable Status Indicator and APC that determine the Medicare payment policy for the services in dispute is as follows:

   - Procedure code 27818 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is assigned APC 5112. The OPPS Addendum A rate is $1,217.42, multiplied by 60% for an unadjusted labor amount of $730.45, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $702.55. The non-labor portion is 40% of the APC rate, or $486.97. The sum of the labor and non-labor portions is $1,189.52. 28 Texas Administrative Code 134.403 (f)(1)(A) requires the Medicare facility specific amount of $1,189.52 is multiplied by 200% for a MAR of $2,379.04.
   - Per the Medicare comprehensive APC policy shown above, Procedure code 99285 is included with payment for the primary J1 procedure. Separate payment is not recommended.

   The total recommended reimbursement for the disputed services is $2,379.04. The insurance carrier paid $2,379.03. The carriers' reduction of payment is supported. No additional payment is 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

		August 10, 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.