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
Service Lloyds Insurance Co

MFDR Tracking Number
M4-18-3993-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
June 14, 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: $311.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill in question was re-priced according to Medical Fee guidelines for the state of Texas that took effect March 1, 2008. There is a ppo reduction taken on the bill which is not being disputed. No additional allowance is recommended at this time."

Response Submitted by: Mitchell International, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2018	65220, 99283	$311.71	$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. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - PP1 – Pricing applied via Prime Health Services

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the disputed services with claim adjustment reason code PP1 – Pricing applied via Prime Health Services." Review of the "TXCOMP ClaimNetwork Summary" at www.tdi.texas.gov, did not find the injured worker was enrolled in a network plan. Review of the Prime Health Services Inc at www.primehealthservices.com, did not find Texas Health Fort Worth to be an in-network provider. The insurance carrier's reduction is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent.

   - Procedure code 65220 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged into payment for any service assigned status indicator S, T or V. This code packaged into Procedure Code 99283 which has a Status Indicator of "V." Separate payment is not recommended.
   - Procedure code 99283 has status indicator J2, denoting outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). However as no hours of observation were submitted on this bill this code is assigned APC 5023 with a status indicator of "V". The OPPS Addendum A rate is $219.10, multiplied by 60% for an unadjusted labor amount of $131.46, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $126.67. The non-labor portion is 40% of the APC rate, or $87.64. The sum of the labor and non-labor portions is $214.31. The Medicare facility specific amount of $214.31 is multiplied by 200% for a MAR of $428.62.
3. The total recommended reimbursement for the disputed services is $428.62. The insurance carrier paid $759.20. 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 documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July 24, 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, 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.