



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 OF ARLINGTON

Respondent Name

TRUMBULL INSURANCE COMPANY

MFDR Tracking Number

M4-18-4041-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

June 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review CPT code 73562, per CMS it pays at an APC rate of \$58.37 x 200% Texas facility uplift; and CPT code 99284, per CMS it pays at an APC rate of \$324.15 x 200%Texas facility uplift."

Amount in Dispute: \$12.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position statement for consideration in this review.

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 8, 2017	Outpatient Hospital Services	\$12.59	\$12.59

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:
 - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
 - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
 - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE

- 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 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 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.

Review of the materials submitted by the respondent finds that the insurance carrier calculated the MAR using a facility wage index of 0.9318. However, Medicare lists the wage index for this facility as 0.9636.

The division notes that facility wage index factors are current during the Federal fiscal year (as opposed to the calendar year). The Federal fiscal year begins on October 1st. Medicare updated the facility wage index factors applicable to these fee calculations effective October 1, 2017 (FY2018).

Rule §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in the rule.

Rule §134.403(d)(3) further requires that whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

As Medicare's wage index factors for Federal fiscal year 2018 were effective on October 1, 2017, and the disputed services were rendered on December 8, 2017, the division uses the wage factors for FY2018 in calculating the fees in this dispute.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 73562 has status indicator Q1, denoting STV-packaged codes. This code is assigned APC 5521. The OPPS Addendum A rate is \$59.86, multiplied by 60% for an unadjusted labor amount of \$35.92, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of \$34.61. The non-labor portion is 40% of the APC rate, or \$23.94. The sum of labor and non-labor portions is \$58.55, multiplied by 200% for a MAR of \$117.10.
 - Procedure code 99284 has status indicator J2, denoting outpatient visits. 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 labor and non-labor portions is \$325.15. This amount is multiplied by 200% for a MAR of \$650.30.
2. The total recommended reimbursement for the disputed services is \$767.40. The insurance carrier paid \$752.44. The requestor is seeking additional reimbursement of \$12.59. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 \$12.59.

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 \$12.59, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

July 20, 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.

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.