



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

TARRANT COUNTY

MFDR Tracking Number

M4-18-4042-01

Carrier's Austin Representative

Box Number 43

MFDR Date Received

June 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a composite family code under APC 8008 and should be paid at the APC rate with a facility uplift."

Amount in Dispute: \$353.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was paid at CPT code 70553 at APC rate @ 200% AT \$892.81."

Response Submitted by: York Risk Services Group/CareWorks Managed Care Services

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: March 19, 2018, Outpatient Hospital Services, \$353.08, \$353.08

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:
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PYMT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- W3 - ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

## **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 outpatient facility 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](http://www.cms.gov).

Reimbursement for the disputed services is calculated as follows:

- Procedure codes 70553 and 72141 have status indicator Q3 for packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8008, for magnetic resonance imaging (MRI) services with contrast. If a “without contrast” MRI procedure is billed the same day as a “with contrast” MRI, APC 8008 is assigned instead of APC 8007. If a composite includes multiple lines, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line in proportion to other separately paid services on the bill. This line is assigned status indicator S and is not subject to multiple procedure reduction. The OPPS Addendum A rate for APC 8008 is \$871.86, which is multiplied by 60% for an unadjusted labor amount of \$523.12, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of \$504.08. The non-labor portion is 40% of the APC rate, or \$348.74. The sum of the labor and non-labor portions is \$852.82. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$852.82 is multiplied by 200% for a MAR of \$1,705.64.
- Procedure code A9579 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is \$1,705.64. The insurance carrier paid \$1,347.28. The requestor is seeking additional reimbursement of \$353.08. 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 evidence presented by the requestor and respondent available 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 \$353.08.

**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 \$353.08, 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.