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 COMPANY

MFDR Tracking Number
M4-18-4895-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: $1,066.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are upholding the original review of the date of service . . . the only discount taken on this bill other than fee schedule is a PPO discount from Prime."

Response Submitted by: Mitchell International, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 23, 2018	Outpatient Hospital Services	$1,066.31	$343.70

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. 28 Texas Administrative Code §133.2 sets out definitions of terms related to medical bill processing.
4. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
5. Insurance Code 1305.005 sets out requirements regarding notice to injured employees.
6. Insurance Code 1305.006 establishes insurance carrier liability for out-of-network health care.
7. Insurance Code 1305.153 sets out requirements for payment of network and non-network providers.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 236 – THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 616 – THIS CODE HAS A STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.

- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 630 – THIS SERVICE IS PACKAGED WITH OTHER SERVICES PERFORMED ON THE SAME DATE AND REIMBURSEMENT IS BASED ON A SINGLE COMPOSITE APC RATE.
- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- PP1 – PRICING APPLIED VIA PRIME HEALTH SERVICES. FOR INQUIRIES, PLEASE CONTACT 866-348-3887.
- 350 – THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Are services subject to a certified workers' compensation health care network (HCN)?
2. Are the disputed services subject to a network or contractual fee reduction?
3. Under what authority is this dispute decided?
4. What is the recommended payment for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - PP1 – PRICING APPLIED VIA PRIME HEALTH SERVICES. FOR INQUIRIES, PLEASE CONTACT 866-348-3887.

   Based on information maintained by the division, the insurance carrier has not previously reported to the division that this injured employee's claim is subject to a workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305.

   Insurance Code §1305.005(d)(1) requires employers to "obtain a signed acknowledgment from each employee . . . that the employee has received information concerning the network and the network's requirements."

   Per Insurance Code §1305.005(h), "An insurance carrier that establishes or contracts with a network is liable for the payment of medical care under the requirements of Title 5, Labor Code, for an injured employee who does not receive notice until the employee receives notice of network requirements under this section."

   Review of submitted information finds no acknowledgment of signed notice or other documentation to support the injured employee's claim is subject to the requirements of a workers' compensation HCN under Chapter 1305.

   Consequently, the disputed services will be reviewed according to the requirements of Title 5, Labor Code.

2. The respondent states, "the only discount taken on this bill other than fee schedule is a PPO discount from Prime." Review of the submitted information finds no documentation to support the disputed services are subject to a PPO discount or any contractual agreement between the parties to this dispute.

3. The requestor is a hospital that provided emergency services to an injured employee. The respondent asserts payment is subject to a PPO discount; although as found above, the respondent failed to support this assertion. No information was found to support the injured employee is enrolled in an HCN or subject to network rules. Nor was documentation provided to support the health care provider is contracted with the network.

   Insurance Code §1305.006 sets out circumstances under which an insurance carrier that establishes or contracts with a network is liable for out-of-network health care provided to an injured employee; including §1305.006 (1), which states an insurance carrier is liable for emergency out-of-network health care provided to injured employees.

   Insurance Code §1305.153 (c) further requires that out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

The authority of the Division of Workers' Compensation to review disputes involving out-of-network health care provided to injured employees subject to a certified workers' compensation HCN is established in provisions of the Texas Insurance Code, pursuant to the Texas Labor Code and division rules, including Rule §133.307. The disputed services will therefore be reviewed in accordance with the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

4. This dispute regards emergency room services subject to DWC's *Hospital Facility Fee Guideline*, Rule §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 published in the Federal Register, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% 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.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes 36415, 82565, 80048, and 85025 have status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 71045 has status indicator Q3, for conditionally packaged services. As packaging criteria are not met, this line is separately paid. This code is assigned APC 5521. The OPPS Addendum A rate is $62.12, multiplied by 60% for an unadjusted labor amount of $37.27, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $35.91. The non-labor portion is 40% of the APC rate, or $24.85. The sum of the labor and non-labor portions is the Medicare facility specific amount of $60.76, which is multiplied by 200% for a MAR of $121.52.
   - Procedure codes 73110, 12011 and 90471 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for code 96374 with Status S, billed on the same date.
   - Procedure codes 72125, 74177, 70486, 70450, and 71260 have status indicator Q3, for packaged codes paid as a composite. 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 8006, for computed tomography (CT) services including contrast. If a composite includes multiple lines, the charges for the 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. These services do not meet the threshold(s) for outlier payment. The OPPS Addendum A rate for APC 8006 is $500.85, multiplied by 60% for an unadjusted labor amount of $300.51, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $289.57. The non-labor portion is 40% of the APC rate, or $200.34. The sum of the labor and non-labor portions is the Medicare facility specific amount of $489.91. This is multiplied by 200% for a MAR of $979.82.
   - Procedure code 99285 has status indicator J2, denoting an outpatient visit. This code is assigned APC 5025. The OPPS Addendum A rate is $520.85, multiplied by 60% for an unadjusted labor amount of $312.51, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $301.13. The non-labor portion is 40% of the APC rate, or $208.34. The sum of the labor and non-labor portions is the Medicare facility specific amount of $509.47. This is multiplied by 200% for a MAR of $1,018.94.
   - Procedure code 96374 has status indicator S, for procedures not subject to reduction. 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 sum of the labor and non-labor portions is the Medicare facility specific amount of $186.92 is multiplied by 200% for a MAR of $373.84.
   - Procedure codes Q9967, 90715, J2270 and J2405 have status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for other services.

5. The total recommended reimbursement for the disputed services is $2,494.12. The insurance carrier paid $2,150.42. The amount due is $343.70. 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 $343.70.

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 $343.70, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 28, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.