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 Cleburne

**Respondent Name**
Insurance Co of the State of PA

**MFDR Tracking Number**
M4-18-5150-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
August 23, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The purpose of this letter is to inform you that 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:** $41.49

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Our system previous allowed $218.33, so an additional $4.89 is due, which is the amount the provider is requesting. Attached, please find the new EOB with payment history screen and check number showing payment. For CPT code A6197, this code was paid correctly. This CPT Code has a status indicator of N, which indicates this charge is bundled into the primary service and separate payment is not warranted. The carrier continues to stand on its position on the EOB based on this information."

**Response Submitted by:** AIG

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 11, 2017 | A4617, G0463 | $41.49 | $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 reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – The benefit for this services is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 2 – The service is considered incidental, packaged, or bundled into another service or APC payment
   - 3 – Workers' compensation jurisdictional fee schedule adjustment
   - 4 – The charge exceeds the APC rate for this service

**Issues**

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

**Findings**

1. The requestor is seeking additional reimbursement of $41.49 for outpatient hospital services rendered on December 11, 2017. The insurance carrier denied Code A6197 as 1 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   28 Texas Administrative Code §134.403 (d) states,

   > 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 the in the Medicare OPPS, Addendum B at www.cms.gov,

   The status indicator associated with code A6197 is "N – Items and Services Packaged into APC rates." The carrier's denial is supported. The remaining service in dispute is G0463. The maximum allowable reimbursement is calculated below.

2. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

   > The reimbursement calculation used for establishing the 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.* The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 200 percent;

   The Medicare allowable is found at Medicare OPPS Addendum B at www.cms.gov, and is found to be $106.61. This amount is multiplied by 60% for an unadjusted labor amount of $63.97, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $61.64. The non-labor portion is 40% of the APC rate, or $42.64. The sum of the labor and non-labor portions is $104.28. The Medicare facility specific amount of $104.28 is multiplied by 200% for a MAR of $208.56.

3. The total allowable is $208.56. The carrier paid $213.22. 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**

| | | |
|---|---|---|
| | | September 19, 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**.