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
TX HEALTH ARLINGTON

Respondent Name
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-18-5285-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This Request for Reconsideration of adjusted and/or disputed amounts is due to: 991 – Underpaid/denied APC: CPT 73030 and 99283 were underpaid and should be reimbursed as follows: CPT 73030 is reimbursed per APC rate of $60.72 with 200%..."

Amount in Dispute: $188.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines, Rule 134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 31, 2018	Outpatient Hospital Services	$188.82	$188.82

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 56 – Significant, separately identifiable E/M services rendered
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance
   - 4915 – The charge of 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

Issues

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

Findings

1. This dispute regards outpatient hospital 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 (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent for the Outpatient Hospital Services in dispute. , unless a facility or surgical implant provider requests separate payment of implantables. Separate reimbursement for implants was not requested.

   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 code 73030 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met. 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 $60.76. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $60.76 is multiplied by 200% for a MAR of $121.52.

   Procedure code 99283 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). This code is assigned APC 5023. 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 cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $214.31 is multiplied by 200% for a MAR of $428.62.

2. The total recommended reimbursement for the disputed services is $550.14. The insurance carrier paid $360.92. The requestor is seeking additional reimbursement of $188.82. This amount is recommended.

Conclusion

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 $188.82.

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 $188.82, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 10, 2019
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 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.