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 OF ARLINGTON

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
September 13, 2018

Carrier's Austin Representative
Box Number 19

MFDR Date Received
M4-19-0166-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bundling – CPT 96372 was incorrectly denied for bundling. There are no CCI conflicts per attached documentation."

Amount in Dispute: $113.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "it is the carrier's position that this claim has been denied in its entirety per the attached PLN-1. The claimant's injury did not occur in the course and scope of employment."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 11, 2018	Emergency Room Services	$113.50	$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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 2 – Workers' Compensation Medical Treatment Guideline Adjustment.
   - 3 – XF27 – The bill was reviewed in accordance with FS guidelines. No additional payment is recommended.
   - 4 – The service is considered incidental, packaged or bundled into another service or APC payment.
   - 5 – No additional reimbursement allowed after review of appeal/reconsideration
   - 6 – Workers' compensation jurisdictional fee schedule adjustment.
   - 7 – The charge exceeds the APC rate for this service

Issues

1. Are there any unresolved issues of compensability, extent of injury or liability for the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier states in their response that the "claim has been denied in its entirety per the attached PLN-1. The claimant's injury did not occur in the course and scope of employment."

   The insurance carrier did not raise this issue however on the explanations of benefits (EOBs) sent to the health care provider. The insurance carrier paid the services and listed only the above denial reasons on the EOBs.

   Rule §133.307(d)(2)(F) requires that the insurance carrier's response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or reasons for reduction or denial of payment as required by Rule §133.240 constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution.

   Upon review of the insurance carrier response, the division finds the respondent has raised new denial reasons or defenses of which the carrier failed to give any notice to the health care provider during the bill review process or prior to the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise these new denial reasons or defenses during MFDR. Any such new denial reasons or defenses will not be considered in this review.

2. 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 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 73130 and 96372 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. These services are packaged with payment for code 99283 under APC 5023, which is assigned status indicator V denoting outpatient visits.
   - Procedure code 99283 is assigned APC 5023, which has status indicator V denoting outpatient visits. The OPPS Addendum A rate is $219.10, which is 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 the Medicare facility specific amount of $214.31. This is multiplied by 200% for a MAR of $428.62.
   - Procedure code J0690 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

3. The total recommended payment for the services in dispute is $428.62. The insurance carrier paid $428.63, leaving an amount due to the requestor of $0.00. No additional payment 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 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

	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.