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 DALLAS

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-0361-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 70544 is family composite code and is to be reimbursed at 100% of the APC rate … CPT 96374 and 96375 was incorrectly denied and per CMS is payable."

Amount in Dispute: $1,542.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was reduced to $69,868.18 and paid … requests for reconsideration were made and an additional payment of $20.43 was made. The carrier's position remains consistent with its EOB."

Response Submitted by: Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 25, 2018 to April 26, 2018	Outpatient Hospital: 96374, 96375, 70544	$1,542.43	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P300 – The amount paid reflects a fee schedule reduction.
   - MPJ2 – Recommended reimbursement is based on CMS Hospital Outpatient Composite for Comprehensive Observation Services.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - Z652 - Recommendation of payment has been based on a procedure code that best describes the services rendered.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

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 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 code 99285, April 25, 2018, has status indicator J2, for outpatient visits subject to comprehensive packaging if 8 or more hours observation billed. The provider billed 66 hours of observation under code G0378. Review of the submitted records finds Medicare criteria for comprehensive packaging under APC 8011 are met. The OPPS Addendum A rate for APC 8011 is $2,349.82. This is multiplied by 60% for an unadjusted labor amount of $1,409.89, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $1,375.49. The non-labor portion is 40% of the APC rate, or $939.93. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $2,315.42. This is multiplied by 200% for a MAR of $4,630.84.
   - Payment for all other services on the bill — including disputed codes 96374, 96375 and 70544 — is packaged. Reimbursement for all services on the bill is included in the payment for the primary comprehensive J2 service according to Medicare policy regarding comprehensive APCs. Please see *Medicare Claims Processing Manual* Chapter 4, §10.2.3 for further details.

2. The total recommended payment for the disputed services is $4,630.84. The insurance carrier paid $6,888.61. No additional payment is due the requestor.

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	October 26, 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.