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 Harris Methodist

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-19-0384-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
September 24, 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: $304.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An additional payment of $17.28 has been made, in addition to the $909.65 previously paid."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2017	Outpatient Hospital Services	$304.80	$1.03

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 outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reasons for reduction of payment supported based on applicable rules?
2. Is additional payment due?

Findings

1. The requestor is seeking additional reimbursement in the amount of $304.80 for outpatient hospital services rendered on November 28, 2017. The insurance carrier reduced Code 99283 as 370 – "This hospital outpatient allowance was calculated according to the APC rate, plus a markup and P12 – "Workers' compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.403, (f) states,

   > 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's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) and Status Indicator for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates and Status Indicators in the OPPS final rules, available from www.cms.gov.

   - Procedure code 99283 billed November 28, 2017 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). However, the requirements for comprehensive packaging is not met. The status indicator is then "V." This code is assigned APC 5023. The OPPS Addendum A rate is $201.25, multiplied by 60% for an unadjusted labor amount of $120.75, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $116.35. The non-labor portion is 40% of the APC rate, or $80.50. The sum of the labor and non-labor portions is $196.85. The Medicare facility specific amount of $196.85 is multiplied by 200% for a MAR of $393.70. The carrier paid $393.27
   - Procedure code 70486 billed November 28, 2017. The insurance carrier reduced the allowed amount as 630 – "This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate." This code has a status indicator of Q3 or composite APC. The assigned composite is for CT services. All CT codes are combined under APC 8005. The OPPS Addendum A rate is $273.09, multiplied by 60% for an unadjusted labor amount of $163.85, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $157.89. The non-labor portion is 40% of the APC rate, or $109.24. The sum of the labor and non-labor portions is $267.13. The Medicare facility specific amount of $267.13 is multiplied by 200% for a MAR of $534.26. The carrier paid $533.66 ($238.75 and $294.91).

2. The total recommended payment for the services in dispute is $927.96. The amount previously paid by the insurance carrier is $926.93, which leaves an amount due to the requestor of $1.03. 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 $1.03.

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 $1.03, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		November 2, 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.