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
TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

MFDR Tracking Number
M4-19-0575-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
October 2, 2018

## *REQUESTOR'S POSITION SUMMARY*

Requestor's Position Summary: "CPT 25609 with a status indicator J1 should be paid at 100% of the APC payment rate with the 200% TX facility uplift."

Amount in Dispute: $167.71

## *RESPONDENT'S POSITION SUMMARY*

Respondent's Position Summary: "the Provider was properly reimbursed under the Division's fee schedule."

Response Submitted by: Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| December 13, 2017 | Outpatient Hospital Services: 25609 | $167.71 | $167.71 |

## *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:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - NDOC – The documentation that was received does not provide enough detailed information to determine the appropriateness of the billed service/procedure.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 1001 - Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.

## 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 outpatient facility 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 that the Medicare facility specific amount and any outlier payment be multiplied by 200% for these 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 25609 is assigned APC 5114. The OPPS Addendum A rate is $5,221.57, multiplied by 60% for an unadjusted labor amount of $3,132.94, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $3,018.90. The non-labor portion is 40% of the APC rate, or $2,088.63. 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 $5,107.53. This is multiplied by 200% for a MAR of $10,215.06.

2. The total recommended payment for the services in dispute is $10,215.06. The insurance carrier paid $10,015.80. The requestor is seeking $167.71. 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 $167.71.

## *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 $167.71, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

| | Grayson Richardson | 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.

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.