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
CITY OF PLANO

MFDR Tracking Number
M4-19-0834-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC … These codes have different DOS and cannot bundle. No modifiers are needed for CPT A6197."

Amount in Dispute: $80.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the amount previously paid of $448.10 includes all procedures such that other procedures that are included in G0463 are not allowed additional reimbursement."

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 8, 2018 to March 20, 2018	Outpatient Hospital Services; G0463, A6197	$80.66	$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:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PYMT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is the requestor entitled to additional reimbursement?

Findings

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 the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed facility services.

Reimbursement for the disputed services is calculated as follows:

- Procedure code A6197, March 8, 2018, has status indicator N, for packaged codes with no separate payment; reimbursement is included with payment for code G0463 performed on the same date.
- Procedure code A6197, March 20, 2018, has status indicator N, for packaged codes with no separate payment; reimbursement is included with payment for code G0463 performed on the same date.
- Procedure code G0463, March 8, 2018, represents a hospital outpatient visit assigned APC 5012. The OPPS Addendum A rate is $113.69, multiplied by 60% for an unadjusted labor amount of $68.21, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $66.55. The non-labor portion is 40% of the APC rate, or $45.48. The sum of the labor and non-labor portions is the Medicare facility specific amount of $112.03. This is multiplied by 200% for a MAR of $224.06.
- Procedure code G0463, March 20, 2018, represents a hospital outpatient visit assigned APC 5012. The OPPS Addendum A rate is $113.69, multiplied by 60% for an unadjusted labor amount of $68.21, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $66.55. The non-labor portion is 40% of the APC rate, or $45.48. The sum of the labor and non-labor portions is the Medicare facility specific amount of $112.03. This is multiplied by 200% for a MAR of $224.06.

The total recommended reimbursement for the disputed services is $448.12. The carrier paid $448.10. Additional payment is not recommended.

Conclusion

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	November 9, 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.