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 Fort Worth

Respondent Name
Great American Alliance Insurance Co

MFDR Tracking Number
M4-19-1422-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 70496 has a status indicator of Q3 which is paid per composite APC 8006. MPR is applied at 100%, CMS allowed $488.40 x 200% Texas Facility uplift = $976.79."

Amount in Dispute: $409.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I did have our bill review company, Mitchell International, review this again and the attached EOB is what they determined was the additional owed. The revised EOB is date 11/30/18 and the check for the additional $36.68 will be mailed out on 12/4/18. Carrier disputes the additional amount of $409.56 and has paid and additional $36.68 but maintains the bill was then paid properly per TX Fee Schedule and the balance of $409.56 - $36.68 = $372.88 is not owed."

Response Submitted by: Great American Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2018	Outpatient hospital services	$409.56	$375.91

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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $409.56 for outpatient hospital services rendered on March 26, 2018. The insurance carrier reduced disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment.

   28 Texas Administrative Code §134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4. The application of this payment policy in conjunction with the Division fee guideline is discussed below.

2. 28 TAC §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; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   Review of the medical bill finds separate payment for implants was not requested. 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.

   The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure codes 70450, and 70496 have status indicator Q3, for packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast. If a "without contrast" CT and a "with contrast" CT are billed together, APC 8006 is assigned instead of APC 8005. This line is assigned status indicator S, for procedures not subject to reduction. This code is assigned APC 8006. The OPPS Addendum A rate is $500.85, multiplied by 60% for an unadjusted labor amount of $300.51, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $289.57. The non-labor portion is 40% of the APC rate, or $200.34. The sum of the labor and non-labor portions is $489.91. The Medicare facility specific amount of $489.91 is multiplied by 200% for a MAR of $979.82.

- Procedure code 99285 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed) but as 8 or more hours were not billed this code is assigned APC 5025. The OPPS Addendum A rate is $520.85, multiplied by 60% for an unadjusted labor amount of $312.51, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $301.13. The non-labor portion is 40% of the APC rate, or $208.34. The sum of the labor and non-labor portions is $509.47. The Medicare facility specific amount of $509.47 is multiplied by 200% for a MAR of $1,018.94.
- Procedure code 70551 has status indicator Q3, for packaged codes paid through a composite APC (if OPPS criteria are met) but as the criteria for composite is not met, this code is assigned status indicator S, for procedures not subject to reduction and APC 5523. The OPPS Addendum A rate is $232.31, multiplied by 60% for an unadjusted labor amount of $139.39, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $134.32. The non-labor portion is 40% of the APC rate, or $92.92. The sum of the labor and non-labor portions is $227.24. The Medicare facility specific amount of $227.24 is multiplied by 200% for a MAR of $454.48.

3. The total recommended reimbursement for the disputed services is $2,453.24. The insurance carrier paid $2,077.33. The amount due is $375.91. 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 $375.91.

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 $375.91, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 12, 2018 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.