



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

CHURCH MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-19-1752-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

November 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Original appeal included all current fee schedule calculations however was still underpaid by carrier."

Amount in Dispute: \$513.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor was reimbursed pursuant to the Medicare fee guidelines for the billed procedure."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: May 11, 2018, Outpatient Hospital - Emergency Room Services, \$513.08, \$513.08

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 OR HAS SUBMISSION/BILLING ERROR(S).
- 270 - NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICE/SUPPLY PLEASE SEE SPECIAL *NOTE* BELOW
- PER "TDI Title 28 Chapter 134 801 providers only have 95 days to submit medical bills for payment form the date of service"
- 790 - THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
- 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.

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 72100 represents a spinal X-ray. This code is assigned APC 5522 with status indicator S, for procedures not subject to reduction. The OPPS Addendum A rate is \$114.46, multiplied by 60% for an unadjusted labor amount of \$68.68, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of \$66.18. The non-labor portion is 40% of the APC rate, or \$45.78. The sum of the labor and non-labor portions is \$111.96. The Medicare facility specific amount of \$111.96 is multiplied by 200% for a MAR of \$223.92.
- Procedure code 99283 represents an emergency room visit. This code is assigned APC 5023. The OPPS Addendum A rate is \$219.10, multiplied by 60% for an unadjusted labor amount of \$131.46, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of \$126.67. The non-labor portion is 40% of the APC rate, or \$87.64. The sum of the labor and non-labor portions is \$214.31. The Medicare facility specific amount of \$214.31 is multiplied by 200% for a MAR of \$428.62.

The total recommended reimbursement for the disputed services is \$652.54. The insurance carrier paid \$138.98. The requestor is seeking additional reimbursement of \$513.08. 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 \$513.08.

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 \$513.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

December 20, 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. A party seeking review must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWCO45M) 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.