



# 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 Rockwall

**Respondent Name**

LM Insurance Corp

**MFDR Tracking Number**

M4-19-2399-01

**Carrier's Austin Representative**

Box Number 1

**MFDR Date Received**

December 31, 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:** \$75.25

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The bill has been reviewed and payment is correct as Under OPPS rules, the wage index is applied to 60% of the APC rate."

**Response Submitted by:** Liberty Mutual Insurance

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22 - 23, 2018	Outpatient Hospital Services	\$75.25	\$75.25

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 4097 – Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider's charge
  - 802 – Charge for this procedure exceeds the OPPS schedule allowance

**Issues**

1. Is the insurance carrier’s reason for reduction supported?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking additional reimbursement in the amount of \$75.25 for outpatient hospital services rendered on May 22 – 23, 2018. The insurance carrier reduced the disputed services with claim adjustment reason code 4097 – “Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider’s charge.”

28 Texas Administrative Code §134.403 (e) (2) and (f) (1) states in pertinent part,

**Regardless of billed amount**, reimbursement shall be:

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

(f) (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 found implants are not applicable. The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 24342 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is assigned APC 5114. The OPSS Addendum A rate is \$5,606.42, multiplied by 60% for an unadjusted labor amount of \$3,363.85, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of \$3,281.77. The non-labor portion is 40% of the APC rate, or \$2,242.57. The Medicare facility specific amount of \$5,524.34 is multiplied by 200% for a MAR of \$11,048.68.

2. The total recommended reimbursement for the disputed services is \$11,048.68. The insurance carrier paid \$10,967.96. The requestor is seeking additional reimbursement of \$75.25. 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 \$75.25.

***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 \$75.25, 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	February 6, 2019 Date
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### ***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.**