



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 HEB

Respondent Name

Hartford Underwriters Insurance Co

MFDR Tracking Number

M4-19-2404-01

Carrier's Austin Representative

Box Number 47

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: \$11.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines, Rule 134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 27, 2018, Outpatient Hospital Services, \$11.68, \$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 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
- 802 - Charge for this procedure exceeds the OPPS schedule allowance
- 86 - Service performed was distinct or independent from other services performed on the same day
- 56 - Service performed was distinct or independent from other services performed on the same day

## 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 \$11.68 for outpatient hospital services rendered on October 27, 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](http://www.cms.gov), Claims processing Manual, Chapter 4. Specifically, *10.1.1 - Payment Status Indicators*,

*An OPPS payment status indicator is assigned to every HCPCS code. 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 status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS*

The Division fee guideline of 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.

The maximum allowable reimbursement per the application of the Division policy in conjunction with the Medicare payment policy is calculated as follows:

- Procedure code 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99283 which has a status indicator of V as the criteria of J2 is not met. No separate payment is recommended.
  - Procedure code 99283 has status indicator J2, for outpatient visits if comprehensive packaging is met when 8 or more hours observation billed but, as no observation hours were provided on this date of service, the status indicator is V. 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.
2. The total recommended reimbursement for the disputed services is \$428.62. The insurance carrier paid \$648.32. 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
January 25, 2019  
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.**