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 Denton

Respondent Name
Hartford Accident & Idemnity

MFDR Tracking Number
M4-19-2699-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note you did not pay on any of Q1's billed but you should have processed the highest Q! which is the code 73140."

Amount in Dispute: $130.06

RESPONDENT'S POSITION SUMMARY

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

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2018	Outpatient Hospital Services	$130.06	$7.64

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:
   - 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

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 $130.06 for outpatient hospital services rendered on August 10, 2018. The insurance carrier reduced disputed services with claim adjustment reason codes 4915 – "The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment," and P12 – "Workers' compensation jurisdictional fee schedule adjustment."

   28 TAC §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, Section 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.*

   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 submitted bill finds implants are not applicable. The status indicator and Medicare facility reimbursement are shown below;

- Procedure code 73140 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. Based on the status indicator, this code is packaged into code 99283.
- Procedure code 99283 has status indicator J2 if 8 or more hours observation billed but as observation hours were not provided on this date, the code has a status indicator of V and 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 0.9756 for an adjusted labor amount of $128.25. The non-labor portion is 40% of the APC rate, or $87.64. The sum of the labor and non-labor portions is $215.89. The Medicare facility specific amount of $215.89 is multiplied by 200% for a MAR of $431.78.

- Procedure code 10120 has status indicator T, for procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This code is paid at 100%. This code is assigned APC 5052. The OPPS Addendum A rate is $310.80, multiplied by 60% for an unadjusted labor amount of $186.48, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $181.93. The non-labor portion is 40% of the APC rate, or $124.32. The sum of the labor and non-labor portions is $306.25. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $306.25 is multiplied by 200% for a MAR of $612.50.
- Procedure code 90715 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code 90471 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. Based on the status indicator, this code is packaged into code 99283.

2. The total recommended reimbursement for the disputed services is $1,044.28. The insurance carrier paid $1,036.64. The amount due is $7.64. 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 $7.64.

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 $7.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		February 28, 2019
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, 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.