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
East Texas Medical Center

Respondent Name
Southeastern Freight Lines Inc

MFDR Tracking Number
M4-19-2833-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
January 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Texas Fee Schedule Calculations, this bill has been underpaid. CPT Codes 74177 and 99291 were not paid."

Amount in Dispute: $1,643.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bill sin question for bill review audit and payment."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2018	Outpatient Hospital Services	$1,643.54	$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
   - P300 – The amount paid reflects a fee schedule reduction

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 $1,643.54 for outpatient hospital services rendered on July 14, 2018. The insurance carrier reduced disputed services based on the workers compensation jurisdictional fee schedule.

   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, 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 medical billed did not contain a charge for implants. The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 99291 has status indicator J2, for outpatient comprehensive packaging if 8 or more hours observation is billed but, as this is not the case, this has a status indicator of S and is assigned APC 5041. The OPPS Addendum A rate is $733.63, multiplied by 60% for an unadjusted labor amount of $440.18, in turn multiplied by the facility wage index of 0.787 for an adjusted labor amount of $346.42. The non-labor portion is 40% of the APC rate, or $293.45. The sum of the labor and non-labor portions is $639.87. The Medicare facility specific amount of $639.87 is multiplied by 200% for a MAR of $1,279.74.
- Procedure code G0390 has a status indicator S and is assigned APC 5045. The OPPS Addendum A rate is $957.57, multiplied by 60% for an adjusted labor amount of $452.16. The non-labor portion of 40% of the APC rate, or $383.03. The sum of the labor and non-labor portions is $835.19. The Medicare facility specific amount of $835.19 is multiplied by 200% for a MAR of $1,670.38.
- Procedure codes 70496, 70498, 71260, and 74177 have status indicator Q3, for packaged codes paid through a composite APC. 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 0.787 for an adjusted labor amount of $236.50. The non-labor portion is 40% of the APC rate, or $200.34.

The sum of the labor and non-labor portions is $436.84. The Medicare facility specific amount of $436.84 is multiplied by 200% for a MAR of $873.68.

2. The total recommended reimbursement for the disputed services is $3,823.80. The insurance carrier paid $3,823.81. Additional payment is not 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 $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	April 12, 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.