TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-19-3064-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: $1,586.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and adjusted for payment – copies of will be submitted for your review once available."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 31, 2018 to April 2, 2018	Hospital Outpatient Emergency Room Services	$1,586.45	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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. 28 Texas Administrative Code §133.240 sets out requirements regarding medical bill payments and denials.
4. Insurance Code Chapter 1305 sets out requirements for workers' compensation health care networks.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z710 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - MOPS – SERVICES REDUCED TO THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)
   - Z652 - RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
   - MPJ2 – RECOMMENDED REIMBURSEMENT IS BASED ON CMS HOSPITAL OUTPATIENT COMPOSITE FOR COMPREHENSIVE OBSERVATION SERVICES.
   - MCMP – THE FINAL RECOMMENDED REIMBURSEMENT FOR CMS HOSPITAL OUTPATIENT APC COMPOSITE IS REFLECTED ON THIS LINE. (MCMP)
   - MSIN – THIS IS A PACKAGED ITEM. SERVICES OR PROCEDURES INCLUDED IN THE APC RATE, BUT NOT PAID SEPARATELY
   - MNSR – REVENUE CODES AND OTHER PACKAGED PROCEDURES ARE NOT SEPARATELY REIMBURSABLE AND ARE TO BE PACKAGED INTO OTHER SERVICES WHEN BILLED ON AN OUTPATIENT BASIS.

- MOTH – OUTPATIENT PROCEDURES SUBJECT TO MODIFIER REDUCTION.
- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
- W3 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCH
- B13 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE.
- 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
- 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED
- 4958 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS J2 COMPREHENSIVE ADJUSTMENT FEE SCHEDULE ALLOWANCE.
- 4097 - PAID PER FEE SCHEDULE; CHARGE ADJUSTED BECAUSE STATUTE DICTATES ALLOWANCE IS GREATER THAN PROVIDER'S CHARGE.
- 926 – THE RECOMMENDED ALLOWANCE IS BASED ON MEDICARE CLINICAL LAB SCHEDULE.

Issues

1. Is this dispute eligible for medical fee dispute resolution?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent asserts the injured employee's claim is subject to a certified workers' compensation health care network (HCN); however, the respondent did not present any documentation to support that payment is subject to the provisions of a certified workers' compensation HCN established in accordance with Insurance Code Chapter 1305. Based on records maintained by the division, the injured employee's claim was not subject to a certified HCN on the date of injury or on the date of treatment.

   Furthermore, 28 Texas Administrative Code §133.240(f)(15) requires the paper form of any explanation of benefits to include notice of the name of any applicable workers' compensation health care network. Review of the submitted documentation finds no notice to the provider on the explanations of benefits, or elsewhere, that the claim is subject to the provisions of a certified workers' compensation HCN or of the name of any certified workers' compensation HCN. The division thus concludes the insurance carrier failed to meet the requirements of Rule §133.240(f)(15).

   28 Texas Administrative Code §133.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The insurance carrier's failure to give notice to the health care provider of the name of any applicable certified workers' compensation HCN or related defenses on the explanations of benefits — or at any time before the filing of the medical fee dispute request — constitutes grounds for the division to find a waiver of such defenses during Medical Fee Dispute Resolution.

   As the respondent did not present any notice to the requestor regarding a certified HCN prior to the filing of the request for medical fee dispute resolution, the division concludes the respondent has waived the right to raise this defense. Any newly raised denial reasons or defenses shall not be considered in this review.

   Consequently, this dispute is eligible for review pursuant to the Texas Labor Code and applicable division rules.

2. 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 emergency department 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 99285 has status indicator J2, for outpatient visits subject to comprehensive packaging if 8 or more hours observation billed. The provider billed more than 8 hours observation and Medicare criteria for comprehensive packaging are met. This code is assigned APC 8011. The OPPS Addendum A rate is $2,349.82, multiplied by 60% for an unadjusted labor amount of $1,409.89, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $1,358.57. The non-labor portion is 40% of the APC rate, or $939.93. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility amount of $2,298.50. This is multiplied by 200% for a MAR of $4,597.00.
- Payment for all other services on the bill is packaged with the primary comprehensive J2 service per Medicare policy regarding comprehensive APCs — including payment status K procedure J2407 (oritavancin injection). Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

The total recommended reimbursement for the disputed services is $4,597.00. The insurance carrier presented documentation to support total payment of $10,738.98 to the provider. Additional payment is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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

	Grayson Richardson	April 5, 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.

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 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.