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
ARISE HEALTHCARE SYSTEM

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-3162-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
February 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Fee Schedule Guidelines state when no split billing is requested reimbursement is at 200% of Medicare rates."

Amount in Dispute: $421.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the audit reimbursed in accordance with the Division Rules and payment policies."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 2, 2018	Outpatient Hospital Services – CPT 27827	$421.52	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 4097 - PAID PER FEE SCHEDULE; CHARGE ADJUSTED BECAUSE STATUTE DICTATES ALLOWANCE IS GREATER THAN PROVIDER'S CHARGE.
   - 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.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, requiring reimbursement to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System formulas and factors 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 these facility services.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 27827 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5115. The OPPS Addendum A rate is $10,122.92. This is multiplied by 60% for an unadjusted labor amount of $6,073.75, which is in turn multiplied by the facility wage index of 0.9417 for an adjusted labor amount of $5,719.65. The non-labor portion is 40% of the APC rate, or $4,049.17. The cost of services does not exceed the threshold for outlier reimbursement. The sum of the labor and non-labor portions is the Medicare facility specific amount of $9,768.82. This is multiplied by 200% for a MAR of $19,537.64.
- Payment for all other services on the bill is packaged with the primary comprehensive J1 service according to Medicare policy regarding comprehensive APCs. Reimbursement for all items is included in the payment for the primary procedure. Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

The total recommended reimbursement for the disputed services is $19,537.64. The insurance carrier paid $19,537.64. 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

	Grayson Richardson	March 15, 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.