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
MIDLAND MEMORIAL HOSPITAL

Respondent Name
STARNET INSURANCE COMPANY

MFDR Tracking Number
M4-19-3327-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HCPCS's are payable at 200% of the correct fee schedule allowable. Please note, per the NCCI Edits this line is not bundled and with a status indicator of 'Q1' and the only other code billed is a 'Q3' it is not bundled into the Q3 per the NCCI edits."

Amount in Dispute: $105.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our Fee Schedule team has determined that the allowable is correct and the provider is not due any additional allowance…"

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 23, 2018	Outpatient Hospital Services: CPT 71046, 93005	$105.86	$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:
   - 663 – P12 – REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES.
   - 223 – P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P300 – The amount paid reflects a fee schedule reduction.
   - MOPS – Services reduced to the Outpatient Prospective Payment System (OPPS)
   - MSIN – in accordance with CMS guidelines, this is a packaged service and is not paid separately. However, charges related to this service is used to pay other payable services a
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - W3 – Request for reconsideration.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- ZE10 – W3-Request for reconsideration.

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(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% to calculate the maximum allowable reimbursement (MAR) for these disputed facility services.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 71046 has status indicator Q3. As packaging criteria are not met, this line is separately paid under APC 5521, which is assigned status indicator S. This line is assigned status indicator S, for significant outpatient procedures not subject to reduction. The OPPS Addendum A rate is $62.12, which is multiplied by 60% for an unadjusted labor amount of $37.27. This is in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of $33.43. The non-labor portion is 40% of the APC rate, or $24.85. The sum of the labor and non-labor portions is the Medicare facility specific amount of $58.28. This is multiplied by 200% for a MAR of $116.56.
- Procedure code 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for procedure code 71046 above—which is assigned APC 5521 with status indicator S. This code is not separately paid unless all OPPS criteria are met.

The total recommended reimbursement for the disputed services is $116.56. The insurance carrier paid $117.52. 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 29,2019
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.