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 OF ARLINGTON

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-19-3460-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 18, 2019

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $34.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and adjusted for payment …"

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 26, 2018 to March 27, 2018	Outpatient Hospital Services:78102, 78806	$34.79	$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:
   - 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.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - 876 – FEE SCHEDULE AMOUNT IS EQUAL TO THE CHARGE.
   - X628 – THIS CHARGE WAS BILLED IN ERROR.
   - Z652 - RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
   - X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE.

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 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 facility 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 78102 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5591. The OPPS Addendum A rate is $349.44, multiplied by 60% for an unadjusted labor amount of $209.66, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $202.03. The non-labor portion is 40% of the APC rate, or $139.78. The sum of the labor and non-labor portions is $341.81. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $341.81 is multiplied by 200% for a MAR of $683.62.
- Procedure code 78806, billed March 27, 2018, has status indicator S, for procedures not subject to reduction. This code is assigned APC 5593. The OPPS Addendum A rate is $1,202.68, multiplied by 60% for an unadjusted labor amount of $721.61, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $695.34. The non-labor portion is 40% of the APC rate, or $481.07. The sum of the labor and non-labor portions is $1,176.41. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $1,176.41 is multiplied by 200% for a MAR of $2,352.82.

The total recommended reimbursement for the disputed services is $3,036.44. The insurance carrier paid $3,036.44 (plus an additional $1.71 in interest). 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	April 12, 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.