



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 DENTON

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-19-3511-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

March 21, 2019

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$365.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The was paid in accordance with Outpatient OPPS/APC fee schedule guidelines..."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 1, 2018	Outpatient Hospital Services: 76770	\$365.13	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
 - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
 - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
 - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. 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 modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount be multiplied by 200% for this facility service.

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 76770 is assigned APC 5522 with status indicator S, for procedures not subject to reduction. The OPPS Addendum A rate is \$114.46, multiplied by 60% for an unadjusted labor amount of \$68.68, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of \$67.00. The non-labor portion is 40% of the APC rate, or \$45.78. The sum of the labor and non-labor portions is the Medicare facility specific amount of \$112.78. This is multiplied by 200% for a MAR of \$225.56.

The total recommended payment for the disputed service is \$225.56. The insurance carrier paid \$225.57. No additional payment is 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 DWCO45M) 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 prefriere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.