



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 HEB

Respondent Name

NATIONAL AMERICAN INSURANCE COMPANY

MFDR Tracking Number

M4-19-4057-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

May 7, 2019

Response Submitted By

None submitted

REQUESTOR'S POSITION SUMMARY

"Underpaid/denied APC."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 15, 2018	Outpatient Hospital Services: CPT 25606	\$28.94	\$28.94

AUTHORITY

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 division provided a copy of the Medical Fee Dispute Resolution request to the insurance carrier's Austin representative, receipt acknowledged May 14, 2019. Pursuant to 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Consequently, this decision is based on the information available at the time of review.
- The insurance carrier reduced payment for the disputed service with the following claim adjustment codes:
 - 97A – Provider appeal
 - LT – Left Side
 - P12 – Workers' Compensation State Fee Schedule Adj.
 - W3 – Appeal/ Reconsideration.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The Austin carrier representative for National American Insurance Company is JT Parker & Associates, LLC, who acknowledged receipt of a copy of the MFDR request on May 14, 2019. Pursuant to Rule §133.307(d)(1), if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, which requires the maximum allowable reimbursement (MAR) 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 and any outlier payment be multiplied by 200% for the disputed hospital 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 CPT code 25606 is calculated as follows:

- This service is assigned APC 5113 with OPPS Addendum A rate \$2,645.23. This is multiplied by 60% for an unadjusted labor amount of \$1,587.14, and in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of \$1,545.24. The non-labor portion is 40% of the APC rate, or \$1,058.09. The sum of the labor and non-labor portions is the Medicare facility specific amount of \$2,603.33. This amount is multiplied by 200% for a final MAR of \$5,206.66.

The total recommended reimbursement for the disputed services is \$5,206.66. The insurance carrier paid \$5,174.92. The requestor is seeking additional reimbursement of \$28.94. This amount is 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is \$28.94.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor \$28.94, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>August 9, 2019</u>
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. The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.