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 Fort Worth

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-4294-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health of Fort Worth to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the new fee schedule that took effect in March of 2208 for this outpatient surgery."

Amount in Dispute: $2,547.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Cpt code 96365 has (SI) "S", per NCCI edits requires modifier, provider did not bill appropriate modifier for reimbursement. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16 – 18, 2018	Outpatient Hospital Services	$2,547.10	$2,547.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas markup
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup

- 767 – Paid per O/P FG at 200%
- 193 – Original payment decision is being maintained
- 446 – This add-on code has been denied as the principal procedure was not billed
- B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $2,547.10 for outpatient hospital services rendered from July 16 – 18, 2018. The insurance carrier reduced disputed services based on the workers' compensation fee schedule and Medicare's add on code policy.

   28 Texas Administrative Code §134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   Review of the submitted medical bill finds the services were for emergency room services over a period of three days that included thirty-eight hours of observation.

   The Medicare payment policy for this type of emergency room service is found at www.cms.gov, MedLearn Matters Article, MM9486 that states,

   > *Any clinic visit, Type A Emergency Department (ED) visit, Type B ED visit, critical care visit, or direct referral for observation services furnished in a non-surgical encounter by a hospital in conjunction with observation services of eight or more hours, will qualify for comprehensive payment through* C-APC 8011.

   The insurance carrier's denials are not supported. The reimbursement of this comprehensive payment is shown below.

2. The applicable fee guideline is found at 28 TAC §134.403, (f) which states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   >
   > > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > >
   > > > (A) 200 percent; unless
   > > >
   > > > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical bill finds no separate request for implants. The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 99284, billed July 16, 2018, has status indicator J2. This code is assigned APC 8011. The OPPS Addendum A rate is $2,349.82, multiplied by 60% for an unadjusted labor amount of $1,409.89, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $1,358.57. The non-labor portion is 40% of the APC rate, or $939.93. The sum of the labor and non-labor portions is $2,298.50. The Medicare facility specific amount of $2,298.50 is multiplied by 200% for a MAR of $4,597.00.

The total recommended reimbursement for the disputed services is $4,597.00. The insurance carrier paid $805.82. The requestor is seeking additional reimbursement of $2,547.10. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,547.10.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $2,547.10, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 27, 2019 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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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 instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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.