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 Stephenville

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-4856-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The facility did not request separate reimbursement for implants, therefore, according to Rule 134.403 (Facility Fee Guideline – Outpatient) the reimbursement rate is 200% x APC payment rate for facilities."

Amount in Dispute: $2,139.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT code 70450 was paid per OPPS fee guidelines with 200% markup. The provider also disputes payment for G0390… The bill was process in accordance with Medicare claims processing guidelines…"

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2019	70450, G0390	$2,139.85	$27.98

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:
   - 695 – Trauma response must be reported with critical care code 99292 per the Medicare Outpatient Code Editor
   - 370 – This 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)
- P12 – Workers' compensation jurisdictional fee schedule adjustment

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 $2,139.85 for outpatient hospital services rendered on January 11, 2019. The insurance carrier reduced disputed services based on Medicare payment policy and workers' compensation fee guidelines.

   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

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1 - Payment Status Indicators

   > *An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule.*

   Review of the codes in dispute found the following:

   - Procedure codes 72125, and **70450** have status indicator Q3, for packaged codes paid through a composite APC 8005, for computed tomography (CT) services without contrast. The OPPS Addendum A rate is $264.95, multiplied by 60% for an unadjusted labor amount of $158.97, in turn multiplied by the facility wage index of 0.9592 for an adjusted labor amount of $152.48. The non-labor portion is 40% of the APC rate, or $105.98. The sum of the labor and non-labor portions is $258.46. The Medicare facility specific amount of $258.46 is multiplied by 200% for a MAR of $516.92.
   - Procedure code 99284 has status indicator J2, if the criteria for comprehensive observation (more than 8 hours of observation) is met. The criteria is not met, this code has a status indicator of V and is assigned APC 5024. The OPPS Addendum A rate is $360.37, multiplied by 60% for an unadjusted labor amount of $216.22, in turn multiplied by the facility wage index of 0.9592 for an adjusted labor amount of $207.40. The non-labor portion is 40% of the APC rate, or $144.15. The sum of the labor and non-labor portions is $351.55. The Medicare facility specific amount of $351.55 is multiplied by 200% for a MAR of $703.10.
   - Procedure code G0390. The Medicare Claims Processing Manual Chapter 4, Section 160.1 states,

     > *If trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 68x, the hospital may also bill one unit of code G0390, which describes trauma activation associated with hospital critical care services. Revenue code 68x must be reported on the same date of service.*

     Review of submitted medical bill found the criteria described above was not met. No payment is recommended.

   The total recommended reimbursement for the disputed services is $1,220.02. The insurance carrier paid $1,192.04. The amount due is $27.98. 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 $27.98.

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 $27.98, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		August 9, 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, 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.