



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 FORT WORTH

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-18-3819-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC: Multiple CT Scans performed during the same visit, should have paid OMedicare Composite Rate (Composite APC 8005)." [sic]

Amount in Dispute: \$311.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: July 11, 2017, Outpatient Hospital Services - Emergency Room Visit, \$311.36, \$93.09

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 hospital facility fee guideline for outpatient services.
3. 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.
- 618 - THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 767 - PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
- 18 - EXACT DUPLICATE CLAIM/SERVICE
- 224 - DUPLICATE CHARGE.

- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient facility services with payment subject to 28 Texas Administrative Code §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, as published annually in the Federal Register, with modifications set out in the rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200 percent for the disputed emergency visit and diagnostic radiology 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 99283 has status indicator J2, denoting outpatient visits. This code is assigned APC 5023. The OPPS Addendum A rate is \$201.25, multiplied by 60% for an unadjusted labor amount of \$120.75, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of \$116.14. The non-labor related portion is 40% of the APC rate, or \$80.50. The sum of the labor and non-labor portions is \$196.64. The cost of services does not exceed the fixed-dollar threshold of \$3,825. The outlier payment is \$0. The Medicare facility specific amount of \$196.64 is multiplied by 200% for a MAR of \$393.28.
 - Procedure code Q0162 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure codes 70450 and 70486 have status indicator Q3, denoting packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8005, for computed tomography (CT) services without contrast. If a composite includes multiple lines, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line in proportion to other separately paid services on the bill. This line is assigned status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. The OPPS Addendum A rate for APC 8005 is \$273.09, multiplied by 60% for an unadjusted labor amount of \$163.85, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of \$157.59. The non-labor portion is 40% of the APC rate, or \$109.24. The sum of the labor and non-labor portions is \$266.83. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$266.83 is multiplied by 200% for a MAR of \$533.66.
2. The total recommended reimbursement for the disputed services is \$926.94. The insurance carrier paid \$833.85. The amount due is \$93.09. 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 \$93.09.

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 \$93.09, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 3, 2018
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 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.