



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 Plano

Respondent Name

Hartford Casualty Insurance Co

MFDR Tracking Number

M4-18-4746-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

August 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: \$185.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines (Rule 134.403)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2018	Outpatient Hospital Services	\$185.23	\$185.23

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 –Worker's compensation jurisdictional fee schedule adjustment
 - 802 – Charge for this procedure exceeds the OPPS schedule allowance

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment for the services in dispute?

Findings

1. The requestor is seeking additional reimbursement in the amount of \$185.23 for outpatient hospital services rendered on February 12, 2018. 28 Texas Administrative Code §134.403 §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of an implantable. Review of the submitted medical bill finds no implants were submitted or requested.

Medicare’s Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 99283, billed February 12, 2018, has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). Review of the submitted medical bill finds the criteria for comprehensive packaging is not met. This code has a status indicator of “V” and is assigned APC 5023.

The OPPS Addendum A rate is \$219.10, multiplied by 60% for an unadjusted labor amount of \$131.46, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of \$128.25. The non-labor portion is 40% of the APC rate, or \$87.64. The sum of the labor and non-labor portions is \$215.89. The Medicare facility specific amount of \$215.89 is multiplied by 200% for a MAR of \$431.78.

2. The total recommended reimbursement for the disputed services is \$431.78. The insurance carrier paid \$245.66. The requestor is seeking additional reimbursement of \$185.23. 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 \$185.23.

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 \$185.23, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		September 13, 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, 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.