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 ALLIANCE

Respondent Name
AMERISURE INSURANCE COMPANY

MFDR Tracking Number
M4-18-3175-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 99285 TX WC fee schedule does not contain 'lesser of' language. The payer does not have the option to pay lesser of billed charges or fee schedule; they must pay according to Workers Comp fee schedule."

Amount in Dispute: $3,372.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the recommended allowance has been calculated per DWC Rule 134.403."

Response Submitted by: CareWorks, Managed Care Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 26, 2017	Outpatient Hospital Facility Services	$3,372.01	$2,661.24

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.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

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 hospital facility services involving an emergency department visit with more than 8 hours of observation. Payment is subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent for the Emergency Department Evaluation and Observation services in dispute.

   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:

   - Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §290.5.3 – "Billing and Payment for Observation Services Furnished Beginning January 1, 2016," when observation services are reported using HCPCS code G0378 (with 8 or more hours of observation time billed and documented) and also reported with emergency department visit code 99285, if there are no other T status or J1 status codes on the claim, then all services on the claim are subject to comprehensive APC payment under the Comprehensive Observation Services APC 8011. If paid at the comprehensive rate, then all services on the bill are included in the comprehensive payment and no other services receive separate payment.

     Review of the submitted documentation finds that the disputed services meet the criteria for Comprehensive Observation Services and are thus subject to comprehensive payment under APC 8011. The OPPS Addendum A rate for APC 8011 is $2,222.64. This is multiplied by 60% for an unadjusted labor-related amount of $1,333.58, which is multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $1,282.64. The non-labor related portion is 40% of the APC rate, or $889.06. The sum of the labor and non-labor portions is $2,171.70. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $2,171.70 is multiplied by 200% for a MAR of $4,343.40.

2. The maximum allowable reimbursement (MAR) for the services in dispute is $4,343.40.
   The amount previously paid by the insurance carrier is $1,682.16.
   The amount remaining due to the requestor is $2,661.24.

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 division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 $2,661.24.

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 $2,661.24, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	May 18, 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.