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 PLANO

Respondent Name
SENTRY CASUALTY COMPANY

MFDR Tracking Number
M4-18-3548-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS Not Paid. . . . Underpaid/denied APC. . . . Underpaid/Denied Physical Therapy Rate."

Amount in Dispute: $571.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have verified that this bill is paid correctly according to the Texas fees schedule. This bill also qualifies for J2 comprehensive payment under APC 8011."

Response Submitted by: Sentry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 11, 2017 to December 12, 2017	Outpatient Hospital Services	$571.75	$0.00

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:
   - 630 – THIS SERVICE IS PACKAGED WITH OTHER SERVICES PERFORMED ON THE SAME DATE AND REIMBURSEMENT IS BASED ON A SINGLE COMPOSITE APC RATE.
   - 618 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

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 emergency room 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 outpatient facility services in this 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:

   - Procedure code 99284 has status indicator J2, denoting outpatient visits subject to comprehensive packaging if 8 or more hours of observation are billed. 26 hours of observation were reported under HCPCS code G0378. Per Medicare payment policy, when criteria are met, all line items on the claim (with certain limited exclusions not present on this claim) are packaged together as a single comprehensive service paid under APC 8011 (Comprehensive Observation Services). The OPPS Addendum A rate 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 0.9794 for an adjusted labor amount of $1,306.11. The non-labor related portion is 40% of the APC rate, or $889.06. The sum of the labor and non-labor portions is $2,195.17. The cost of services does not exceed the threshold for outlier payment. The sum of $2,195.17 is the Medicare facility specific amount. This is multiplied by the DWC outpatient conversion factor of 200%, resulting in a reimbursement amount of $4,390.34.
   - Payment for all other services on the claim is packaged with the primary comprehensive service in accordance with Medicare payment policy regarding comprehensive APCs. Reimbursement is included with payment for the primary J2 status procedure. Please see Medicare Claims Processing Manual Chapter 4 §10.2.3 for details.

2. The total recommended payment for the disputed services is $4,390.34. The amount paid by the insurance carrier is $4,766.50. The amount due to the requestor is $0.00. Additional payment is not recommended.

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 not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	June 8, 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.