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 ROCKWALL

Respondent Name
EAST TEXAS EDUCATIONAL INSURANCE ASSOCIATION

MFDR Tracking Number
M4-19-2421-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
January 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have attached a UB, the complete Medical Record, and itemized statement and implant invoices if applicable."

Amount in Dispute: $3,732.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "this bill qualifies for J2 comprehensive payment under APC 8011."

Response Submitted by: CAS, Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 9, 2018 to August 11, 2018	Outpatient Hospital Services	$3,732.53	$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:
   - 197 – Precertification/authorization/notification absent
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 446 – THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED.

- 616 – THIS CODE HAS STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 630 – THIS SERVICE IS PACKAGED WITH OTHER SERVICES PERFORMED ON THE SAME DATE AND REIMBURSEMENT IS BASED ON A SINGLE COMPOSITE APC RATE.
- 650 – ALLOWANCE IS REDUCED PER THE MULTIPLE PROCEDURE PAYMENT REDUCTION FOR SELECTED THERAPY SERVICES.
- 721 – PER RULE 134.600 OF THE TEXAS ADMINISTRATIVE CODE, THIS PROCEDURE REQUIRES PREAUTHORIZATION, PREAUTHORIZATION NOT OBTAINED
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §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 published in the Federal Register, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed facility services unless separate payment of implantables is requested. Separate reimbursement for implants was not requested.

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.

When a bill has a code with status indicator J2, billed with 8 or more hours of observation, if criteria are met, Medicare packages payment for all services on the bill into the reimbursement for Comprehensive Observation Services, APC 8011.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 99285 has status indicator J2, for outpatient visits subject to comprehensive packaging if 8 or more hours observation billed. Medicare criteria for comprehensive packaging are met. This code is assigned APC 8011. The OPPS Addendum A rate is $2,349.82, multiplied by 60% for an unadjusted labor amount of $1,409.89, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $1,375.49. The non-labor portion is 40% of the APC rate, or $939.93. The sum of the labor and non-labor portions is $2,315.42. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $2,315.42 is multiplied by 200% for a MAR of $4,630.84.
- Payment for all other services on the bill is packaged with the primary comprehensive J2 service according to Medicare policy regarding comprehensive APCs. Reimbursement for all items is included in the payment for the primary procedure. Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

The total recommended reimbursement for the disputed services is $4,630.84. The insurance carrier paid $4,987.57. 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 emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available 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	January 25, 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.

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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.