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
UT HEALTH TYLER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-2766-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After the reconsideration was processed, the bill was underpaid."

Amount in Dispute: $5,258.67

RESPONDENT'S POSITION SUMMARY

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

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 12, 2018 to September 13, 2018	Outpatient Hospital Services	$5,258.67	$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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
   - D27 – PROVIDER NOT APPROVED TO TREAT WORKWELL, TX NETWORK CLAIMANT. FOR NETWORK INFORMATION CALL 844-867-2338
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 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.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 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.
- 723 – SUPPLEMENTAL REIMBURSEMENT ALLOWED AFTER A RECONSIDERATION OF SERVICES FOR INFORMATION CALL 1-800-937-6824.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code
   - D27 – PROVIDER NOT APPROVED TO TREAT WORKWELL, TX NETWORK CLAIMANT. FOR NETWORK INFORMATION CALL 844-867-2338

   However, upon reconsideration the carrier did not maintain this denial reason. Consequently, the disputed services will be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. 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 modified by DWC rules.

   Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200%.

   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 99285 has status indicator J2, for outpatient visits subject to comprehensive packaging if 8 or more hours observation billed. The provider billed over 8 hours observation and thus comprehensive packaging is required. This service is assigned APC 5025. The OPPS Addendum A rate is $520.85. This is multiplied by 60% for an unadjusted labor amount of $312.51, which is in turn multiplied by the facility wage index of 0.787 for an adjusted labor amount of $245.95. The non-labor portion is 40% of the APC rate, or $208.34. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $454.29. This is multiplied by 200% for a MAR of $908.58.
   - Certain preventive services are excluded from comprehensive packaging. The insurance company allowed payment for Procedure code 97802, which represents nutritional counseling. This code has status indicator A, for services paid by fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the code on the date provided. Per DWC Professional Fee Guideline, Rule §134.203(c), the facility fee is based on Medicare's Physician Fee Schedule rate for this code of $31.96, divided by the Medicare conversion factor of 35.9996 and multiplied by the DWC conversion factor of 58.31 for a MAR of $51.76
   - Payment for all other services on the bill is packaged with the primary comprehensive J2 service according to Medicare policy regarding comprehensive APCs. Only brachytherapy (status indicator U); pass-through drugs, biologicals and devices (status indicators G or H); corneal tissue, CRNA services, and Hepatitis B vaccinations (status indicator F); influenza and pneumococcal pneumonia vaccine services (status indicator L); ambulance services; mammography; and certain preventive services are excluded from the comprehensive packaging policy. Reimbursement for all other 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 $960.34. The insurance carrier paid $960.64 and $5.84 in additional interest for a total of $966.48. Additional payment is not recommended.

Conclusion

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	February 15, 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.