



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

ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number

M4-19-3060-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Texas Fee Schedule Calculations, this bill and appeal have been underpaid. We seek full Texas Fee Schedule reimbursement."

Amount in Dispute: \$1,400.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The total payment is \$5,916.94 ... the provider is not entitled to any additional payment."

Response Submitted by: Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 11, 2018	Outpatient Hospital Services	\$1,400.25	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 236 – THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
 - 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 SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Is the requestor entitled to additional reimbursement?

Findings

Is the requestor entitled to additional reimbursement?

This dispute regards outpatient emergency room 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.

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. More than 8 hours of observation were billed under code G0378; criteria are thus met for comprehensive packaging. This code is assigned APC 8011 with an OPPS Addendum A rate of \$2,349.82. This amount is multiplied by 60% for an unadjusted labor amount of \$1,409.89, and in turn multiplied by the facility wage index of 0.787 for an adjusted labor amount of \$1,109.58. The non-labor portion is 40% of the APC rate, or \$939.93. 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 \$2,049.51. This is multiplied by 200% for a MAR of \$4,099.02.
- 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 \$4,099.02. The insurance carrier paid \$5,916.94. 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	March 8, 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 DWCO45M) 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.