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
TEXAS HEALTH OF PLANO

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3113-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: $2,575.12

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
June 18, 2018	CPT code 99284	$2,575.12	$2,123.83

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.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 630 – THIS SERVICE IS PACKAGED WITH OTHER SERVICES PERFORMED ON THE SAME DATE AND REIMBURSEMENT IS BASED ON A SINGLE COMPOSITE APC RATE.
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 350 – 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 Emergency Room evaluation and management 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 99284 has status indicator J2, for an outpatient visit subject to comprehensive packaging if 8 or more hours observation are billed. As 17 hours of observation were billed, the criteria for comprehensive packaging are met. This code is assigned APC 8011 with OPPS Addendum A rate of $2,349.82. This is multiplied by 60% for an unadjusted labor amount of $1,409.89, and 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 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 $2,315.42. This is multiplied by 200% for a MAR of $4,630.84.

The total recommended reimbursement for the disputed services is $4,630.84. The insurance carrier paid $2,507.01. The amount due is $2,123.83. This amount is recommended.

Conclusion

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 $2,123.83.

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 $2,123.83, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

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 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.