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
SENTRY INSURANCE A MUTUAL COMPANY

MFDR Tracking Number
M4-19-3142-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT Code 25607-LT has been underpaid."

Amount in Dispute: $212.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have verified that this bill paid correctly according to the Texas Fee Schedule."

Response Submitted by: Sentry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 26, 2018	Outpatient Hospital Services	$212.23	$212.23

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:
   - 618 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
   - 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
   - 616 – THIS CODE HAS STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

Issue

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 these 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.

The division notes the insurance carrier used an incorrect Wage Index factor in calculating the paid amount. While most of Medicare's OPPS formulas and factors are effective during the calendar year (CY) beginning on January 1st, Medicare's Wage Index factors are effective for Medicare's fiscal year (FY), beginning on October 1st.

Rule §134.403(d)(3) requires that:

> Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date…

The disputed date of service is October 6, 2018, which falls within Medicare's Fiscal Year 2019; therefore, use of the revised Wage Factor component is required pursuant to Rule §134.403(d)(3). The effective Wage Index for this facility in FY 2019 is 0.8244.

Medicare wage index information (including effective dates) is available from the Medicare website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html

Reimbursement for the disputed services is calculated as follows:

- Procedure code 25607 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is assigned APC 5114, which has an OPPS Addendum A rate of $5,606.42. This is multiplied by 60% for an unadjusted labor amount of $3,363.85, and in turn multiplied by the facility wage index of 0.8244 for an adjusted labor amount of $2,773.16. The non-labor portion is 40% of the APC rate, or $2,242.57. The costs for this service do not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $5,015.73. This is multiplied by 200% for a MAR of $10,031.46.
- Payment for all other services on the bill is packaged with the primary comprehensive J1 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 $10,031.46. The insurance carrier paid $9,779.84. The requestor is seeking additional reimbursement of $212.23. This amount is recommended.

Conclusion

The division emphasizes the findings in this decision are based on the available evidence presented by the requestor and respondent up to 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 established that additional reimbursement is due. As a result, the amount ordered is $212.23.

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 $212.23, 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 1, 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.