



# 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 HEB

Respondent Name

SENTRY CASUALTY COMPANY

MFDR Tracking Number

M4-19-3445-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 15, 2019

#### REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$31.86

#### 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 25, 2018	Outpatient Hospital Services: 49505	\$31.86	\$31.86

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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:
  - 618 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
  - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
  - 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
  - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
  - 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.

#### 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 these services. 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](http://www.cms.gov).

Reimbursement for the disputed services is calculated as follows:

- Procedure code 49505 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5341 with an OPPS Addendum A rate of \$2,911.16. This is multiplied by 60% for an unadjusted labor amount of \$1,746.70, which is in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of \$1,700.59. The non-labor portion is 40% of the APC rate, or \$1,164.46. 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 \$2,865.05. This is multiplied by 200% for a MAR of \$5,730.10.
- Payment for all other services on the bill is packaged with the primary comprehensive J1 service per Medicare policy regarding comprehensive APCs; see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details.

The total recommended reimbursement for the disputed services is \$5,730.10. The insurance carrier paid \$5,695.16. The requestor is seeking additional reimbursement of \$31.86. 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 \$31.86.

**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 \$31.86, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 5, 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.