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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
SENTRY CASUALTY COMPANY

MFDR Tracking Number
M4-19-3464-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we have concluded that reimbursement was inaccurate … Reimbursement should be $12,435.38. Payment received was only $10,160.97 thus … there is a pending payment … of $2,274.41."

Amount in Dispute: $2,373.66

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 23, 2018	Outpatient Hospital Services	$2,373.66	$0.00

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

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. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. 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.
   - 617 – 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.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 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.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 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 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 facility services. Separate reimbursement for implants was not requested.

Reimbursement for the disputed services is calculated as follows:

- Procedure code L1830 has status indicator A, item paid by fee schedule other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of DWC's fee guideline applicable to the code on the date provided. Per DWC *Professional Fee Guideline*, Rule §134.203(d)(1), the fee is based on Medicare's Durable Medical Equipment (DMEPOS) fee schedule rate for this code of $79.39 multiplied by 125% for a MAR of $99.24.
- Procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate. All services on the bill are packaged together and assigned APC 5114. The OPPS Addendum A rate is $5,606.42. This is multiplied by 60% for an unadjusted labor amount of $3,363.85, which is in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $2,766.43. The non-labor portion is 40% of the APC rate, or $2,242.57. 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 $5,009.00. This is multiplied by 200% for a MAR of $10,018.00.
- Payment for all other services is packaged with the primary comprehensive J1 service according to Medicare policy regarding comprehensive APCs. When multiple J1 status procedures are billed, the APC code is assigned based on the highest paying J1 procedure. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

The total recommended reimbursement for the disputed services is $10,117.24. The insurance carrier paid $10,160.97. 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	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 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.