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

XL INSURANCE AMERICA, INC.

MFDR Tracking Number

M4-19-3726-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 8, 2019

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $887.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the recommended reimbursement was based on CMS Hospital Out-Patient Composite for comprehensive observation services."

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 24, 2018 to November 27, 2018	Emergency Department Services	$887.50	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - MCMP – The final recommended reimbursement for CMS Hospital Outpatient APC Composite is reflected on this line.
   - MOPS – Services reduced to the Outpatient Prospective Payment System (OPPS)
   - MPJ2 – Recommended reimbursement is based on CMS Hospital Outpatient Composite for Comprehensive Observation Services.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P300 – The amount paid reflects a fee schedule reduction.
   - Z652 - Recommendation of payment is based on a procedure code that best describes services rendered.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – Request for reconsideration.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards 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 using Medicare Outpatient Prospective Payment System formulas and factors modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount 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. This code was billed in conjunction with code G0378 with more than 8 hours of observation. This service meets Medicare criteria for comprehensive packaging under Comprehensive Observation Services 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, which is in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $1,372.67. 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 $2,312.60. This is multiplied by 200% for a MAR of $4,625.20.
- Payment for all other services on the bill is packaged with the primary comprehensive J2 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 $4,625.20. The carrier paid $5,601.02. No additional payment is recommended.

Conclusion

For the reasons stated above, the division finds the requestor has not established that additional payment 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	May 2, 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.