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
BAYLOR SCOTT & WHITE EMERGENCY

Respondent Name
SHERWIN WILLIAMS COMPANY

MFDR Tracking Number
M4-19-3804-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
April 10, 2019

Response Submitted By
No response submitted for consideration.

REQUESTOR'S POSITION SUMMARY

"The claim was paid at the physician fee schedule and not the facility fee schedule."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 6, 2018	Outpatient Hospital Services	$677.36	$677.36

AUTHORITY

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 division provided a copy of the Medical Fee Dispute Resolution request to the insurance carrier's Austin representative, receipt acknowledged April 23, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Consequently, this decision is based on the information available at the time of review.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – Processed based on multiple or concurrent procedure rules.
   - MMRI – In accordance with the CMS Physician Fee Schedule guideline, this service was reduced due to the Radiology Diagnostic Imaging Multiple Procedure Rule for the technical c
   - MRCA - This service was reduced in accordance with the Workers' Compensation Fee Schedule rules for Physician Services.

- PFAC – The reimbursement is based on the CMS Physician Fee Schedule Facility site of service rate.
- PFOP – Line fee schedule amount is from Facility OPPS Cap.
- PLAB – The reimbursement is based on the CMS Clinical Lab Fee Schedule.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 00663 – REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES.
- P300 – The amount paid reflects a fee schedule reduction.
- Z710 - The charge for this procedure exceeds the fee schedule allowance.
- ZE10 – W3 - Request for reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

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, which requires the maximum allowable reimbursement (MAR) 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 the disputed hospital 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 81025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 99284 represents an outpatient visit assigned APC 5024. The OPPS Addendum A rate is $355.53. This is multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $207.69. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is the Medicare facility specific amount of $349.90. This is multiplied by 200% for a MAR of $699.80.
- Procedure codes 70450 and 72125 have status indicator Q3, for packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8005, for computed tomography (CT) services without contrast. The OPPS Addendum A rate is $274.84. This is multiplied by 60% for an unadjusted labor amount of $164.90, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $160.55. The non-labor portion is 40% of the APC rate, or $109.94. The sum of the labor and non-labor portions is the Medicare facility specific amount of $270.49. This is multiplied by 200% for a MAR of $540.98.

The total recommended reimbursement for the disputed services is $1,240.78. The insurance carrier paid $443.70. The requestor is seeking additional reimbursement of $677.36. This amount is recommended.

Conclusion

For the reasons above, the division that additional payment is due. As a result, the amount ordered is $677.36.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $677.36, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 19, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.