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
INSURANCE COMPANY OF THE STATE OF PA

MFDR Tracking Number
M4-19-4027-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 3, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for review with their request.

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
December 4, 2018	Outpatient Hospital Services	$212.23	$212.23

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 May 15, 2019. 28 Texas Administrative Code §133.307(d)(1) states:

   > 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 carrier has not responded. This decision is thus 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:
   - 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.
   - MJ1N — Recommended reimbursement is based on CMS Hospital Outpatient status indicator J1: Comprehensive APC Non-Complexity Adjustment.
   - MOPS – Services reduced to the Outpatient Prospective Payment System (OPPS)
   - MCMP – The final recommended reimbursement for CMS Hospital Outpatient APC Composite is reflected on this line.

- 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.
- ZD86 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- ZE10 – W3- Request for reconsideration.
- W3 – Request for reconsideration.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The Austin carrier representative for the Insurance Company of the State of PA is the law firm of Flahive, Odgen & Latson, who acknowledged receipt of a copy of the MFDR request on May 15, 2019. Rule §133.307(d)(1) states that if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

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 these 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.

The requestor's form DWC-60 *Table of Disputed Services* indicates that only Revenue Code 360 is in dispute. Three procedure codes were found with Revenue Code 360 on the disputed bill: 29824, 29826 and 29827. Reimbursement for those services is calculated as follows:

- Procedure code 29824 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. There are two J1 status codes on this bill. Primary status is determined using OPPS Addendum J. 29824 is not the primary J1 service. Payment for this procedure is included in the comprehensive reimbursement for code 29827 below.
- Procedure code 29826 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. Per OPPS Addendum J, this code is the primary J1 service for this bill. This code is assigned APC 5114. The OPPS Addendum A rate is $5,606.42, which is multiplied by 60% for an unadjusted labor amount of $3,363.85, 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 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 primary comprehensive J1 service code 29827 per Medicare policy. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 regarding comprehensive APCs.

The total recommended reimbursement for the disputed services is $10,031.46. The insurance carrier paid $9,799.84. The requestor is seeking additional reimbursement of $212.23. This amount is recommended.

Conclusion

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $212.23.

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 $212.23, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 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.

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.