



# 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 DALLAS

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-19-4261-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

May 28, 2019

**Response Submitted By**

Texas Mutual Insurance Company

#### REQUESTOR'S POSITION SUMMARY

"Underpaid/denied APC: CPT 99285 is showing underpaid and should be calculated at CMS allowable of \$2347.73 x 200% facility uplift..."

#### RESPONDENT'S POSITION SUMMARY

"TEXAS HEALTH DALLAS, was paid in accordance with Rule 134.403(3)(d)(f)."

#### SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 26, 2019	Emergency Department Evaluation Services: 99285	\$3,661.50	\$3,045.60

#### 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

- 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:
  - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
  - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
  - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
  - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
  - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
  - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issue

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, 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 be multiplied by 200% for these 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](http://www.cms.gov).

Reimbursement for the disputed services is calculated as follows:

- Procedure code 99285 has status indicator J2 – outpatient visit subject to comprehensive packaging if 8 or more hours observation are billed. 28 hours of observation are reported under code G0378 and no T status procedure codes are present on the bill. Medicare criteria for comprehensive packaging are thus met. This code is assigned Comprehensive Observation Services APC 8011. The OPPS Addendum A rate is \$2,386.8. This is multiplied by 60% for an unadjusted labor amount of \$1,432.08, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of \$1,394.27. The non-labor portion is 40% of the APC rate, or \$954.72. 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 \$2,348.99. This is multiplied by 200% for a MAR of \$4,697.98.
- 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.

Total reimbursement for the disputed services is \$4,697.98. The insurance carrier paid \$1,652.38.

The amount remaining due is \$3,045.60. This amount is recommended.

Conclusion

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is \$3,045.60.

**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 \$3,045.60, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 12, 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.