TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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## *AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

### *GENERAL INFORMATION*

**Requestor Name**
UT Health Athens

**Respondent Name**
Travelers Indemnity Insurance

**MFDR Tracking Number**
M4-20-0168-02

**Carrier's Austin Representative**
Box Number 5

**MFDR Date Received**
September 18, 2019

### *REQUESTOR'S POSITION SUMMARY*

"This bill has been underpaid."

### *RESPONDENT'S POSITION SUMMARY*

"The Provider contends they are entitled to additional reimbursement for the emergency room visit. The Carrier has reviewed the documentation and determined the Provider was properly reimbursed."

**Response received from:** Travelers

### *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 14, 2019 | Outpatient hospital services | $652.18 | $652.18 |

### *AMENDED FINDINGS AND DECISION*

By Official Order Number 2807 dated October 17, 2013, the undersigned has been delegated authority by the Commissioner to **amend** fee dispute decisions.

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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:
    - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
    - 309 – The charge for this procedure exceeds the fee schedule allowance
    - 56 – Significant, separately identifiable E/M service rendered
    - DUPL – These services have already been considered for reimbursement

**Issues**

1. Is the requestor entitled to additional reimbursement?

**Findings**

1. This dispute regards Emergency Room services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §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 28 TAC 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 80307 has status indicator Q4, for packaged labs; reimbursement is included with pay for the primary services.
    - Procedure code 96360 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $187.18, multiplied by 60% for an unadjusted labor amount of $112.31, in turn multiplied by the facility wage index of 0.8244 for an adjusted labor amount of $92.59. The non-labor portion is 40% of the APC rate, or $74.87. The sum of the labor and non-labor portions is the Medicare facility specific amount of $167.46. This is multiplied by 200% for a MAR of $334.92.
    - Procedure code 99284 represents an emergency room visit assigned APC 5024. The OPPS Addendum A rate is $360.37, multiplied by 60% for an unadjusted labor amount of $216.22, in turn multiplied by the facility wage index of 0.8244 for an adjusted labor amount of $178.25. The non-labor portion if 40% of the APC rate, or $144.15. The sum of the labor and non-labor portions is the Medicare facility specific amount of $322.40 multiplied by 200% for a MAR of $644.80.

   The total recommended reimbursement for the disputed services is $979.72. The insurance carrier paid $323.69. The requestor is seeking additional reimbursement of $652.18. This amount is recommended.

**Conclusion**

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has established payment is due. As a result, the amount ordered is $652.18.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $652.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | October 31, 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 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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 instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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**.