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
Midland Memorial Hospital

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-20-0186-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
September 19, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the TDI/DWC fee schedule this account qualifies for an Outlier payment… The correct allowable due is $7,131.24. After their payment of $4,445.30, an outstanding balance of $2,685.93 is still due."

Amount in Dispute: $2,685.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and pricing is correct as our system did the outlier calculation, but the APC allowance did not exceed the outlier threshold; therefore, outlier was not met."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 28 – 29, 2019	Outpatient hospital services	$2,685.93	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 reimbursement guidelines for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4958 – Charge for this procedure exceeds the OPPS J2 comprehensive adjustment fee schedule allowance
   - 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

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in December 28 – 29, 2018. The insurance carrier reduced the allowed amount based on the OPPS comprehensive fee schedule and the payment status indicators.

   28 TAC §134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment policies for coding, billing, reporting, and reimbursement of health care covered in effect on the date a service is provided.

   Review of the applicable Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1 specifically payment status indicators that determine whether payment is made separately or packaged, and whether payment is under OPPS or under another payment or fee schedule.

   Review of the submitted medical bill was reviewed based on the applicable Medicare and DWC guidelines.

   Procedure code 99285 has status indicator J2 and is classified as a Comprehensive Observation APC 8011 when billed in conjunction with 8 or more hours of observation. The total hours of observation for the disputed dates of service was twenty-nine. The J2 APC is applicable.

   A status indicator of J2 packages all other covered Part B services into a single payment. All the other services submitted on the medical bill are packaged into the payment for this service.

   This comprehensive APC is assigned APC 8011. The OPPS Addendum A rate is $2,349.82, multiplied by 60% for an unadjusted labor amount of $1,409.89, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of $1,264.53. The non-labor portion is 40% of the APC rate, or $939.93. The sum of the labor and non-labor portions is $2,204.46. The Medicare facility specific amount of $2,204.46 is multiplied by 200% for a MAR of $4,408.92.

   The CMS Claims Processing Manual, Chapter Four, Section 10.7.1 at www.cms.gov, states,

   > *The current outlier payment is determined by:*
   >
   > > *Determining whether the total cost for a service **exceeds 1.75 times the OPPS payment** and **separately** exceeds the fixed-dollar threshold determined each year;*

   Medicare MedLearn Matters Article MM10417 states,

   The current outlier payment is determined by:

   > *The fixed-dollar threshold for OPPS outlier payments increases in CY 2018 relative to CY 2017. The estimated cost of a service **must be greater than the APC payment amount plus $4,150** in order to qualify for outlier payments.*

The cost of services does not exceed the threshold described above. No additional payment is due.

Conclusion

For the reasons stated above, DWC finds that the requestor has not established that additional reimbursement 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

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

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.