TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UT HEALTH PITTSBURG

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-1390-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 04, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per our calculations, this bill has been underpaid."

Amount in Dispute: $235.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute for date of service 11/15/2019 to 11/15/2019. The requestor billed $1,450.00; Texas Mutual paid $199.45. The requestor believes it is entitled to an additional $235.55.

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 15, 2019	Outpatient Hospital Services	$235.55	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 991 – Underpaid/denied APC
   - CAC-P12 – Workers Compensation jurisdictional fee schedule adjustment
   - CAC-W3 – In accordance with TDI DWC Rule 134.804, this bill has been identified that this claim was processed properly
   - CAC-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
- 370 – This 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)

Issues

1. What is the recommended payment amount for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent for Outpatient services in dispute, unless a facility or surgical implant provider requests separate payment of implantables.

   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 73700 has status indicator Q3, for packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8005. As packaging criteria are not met, this line is separately paid. This line is assigned status indicator S, for procedures not subject to reduction. This code is assigned APC 5522. The OPPS Addendum A rate is $112.51. This is multiplied by 60% for an unadjusted labor amount of $67.51, in turn multiplied by facility wage index 0.8092 for an adjusted labor amount of $54.63. (Please note: Medicare updates Wage Index factors every October 1st, effective for the Federal Fiscal Year – not the calendar year.) The non-labor portion is 40% of the APC rate, or $45.00. The sum of the labor and non-labor portions is $99.63. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $99.63. This is multiplied by 200% for a MAR of $199.26.

2. The total recommended reimbursement for the disputed services is $199.26. The insurance carrier paid $199.45. Additional payment is not recommended.

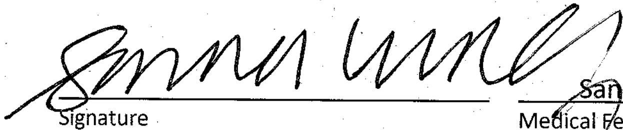
Conclusion

For the reasons stated above, the Division 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, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature



Signature	Sandra Hernandez Medical Fee Dispute Resolution Officer	March 12, 2020 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.