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 HEB

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-0352-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above refenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $4,092.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was paid correctly. No additional payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2018	Outpatient Hospital Services	$4,092.94	$3,578.05

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 hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $4,092.94 for outpatient hospital services rendered on June 13, 2018. The insurance carrier reduced disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment" and 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   28 Texas Administrative Code §134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4. The application of this payment policy in conjunction with the Division fee guideline is discussed below.

2. 28 Texas Administrative Code §134.403, (f) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 200 percent; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   Review of the medical bill finds separate payment for implants was not requested. The maximum allowable reimbursement is calculated as follows.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) and Status Indicator for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates and Status Indicators in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure Codes 96361 and 96374. Review of the submitted medical bill found Code 96361 and 96374 were billed with Codes 99285 and G0283 for 44 units. This qualifies these services as a "J2" status indicator with an APC of 8011 as found at www.cms.gov, Med Learn Matters Article MM9486.

     The applicable Medicare payment policy is found at www.cms.gov, Chapter, Section 10.4, C. Packaging Types Under the OPPS states, "J2 services are assigned to comprehensive APCs when a specific combination of services are reported on the claim. Payment for **all adjunctive services reported on the same claim as a J2 service is packaged into payment for the J2 service** when certain conditions are met." As Code 99285 has a J2 status indicator, separate payment is not recommended.

- Procedure code 99285 has status indicator J2, comprehensive observation packaging as more than 8 hours of observation billed. This code 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 0.9636 for an adjusted labor amount of $1,358.57. The non-labor portion is 40% of the APC rate, or $939.93. The sum of the labor and non-labor portions is $2,298.50. The Medicare facility specific amount of $2,298.50 is multiplied by 200% for a MAR of $4,597.00.

3. The total recommended reimbursement for the disputed services is $4,597.00. The insurance carrier paid $1,018.95. The amount due is $3,578.05. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor established that additional reimbursement is due. As a result, the amount ordered is $3,578.05.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $3,578.05, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 31, 2018 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 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 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 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.