TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Denton

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-19-0277-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the billed CPTs for the individual dates of services shows that there are not existing CCI conflicts of bundling and these codes are each separately reimbursable. CPT 99285 was underpaid…"

Amount in Dispute: $5,682.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines, 134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1 – 2, 2018	Outpatient Hospital Services	$5,682.06	$3,604.40

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

Findings

1. The requestor is seeking additional reimbursement in the amount of $5,682.06 for outpatient hospital services rendered on May 1-2, 2018. The insurance carrier reduced disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment, 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 packed or excluded from payment."

   28 TAC §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 TAC §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 code 71045 has a status indicator of Q3. The medical bill contained codes 99285 and G0283 for 26 hours of observation meeting the criteria for comprehensive packing or the J2 Status Indicator. The J2 status indicator is defined as, "Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services." As this status indicator is not exempt this service is packaged. The insurance carrier's denial is supported.

- Procedure code 70450 has a status indicator of Q3. The medical bill contained codes 99285 and G0283 for 26 hours of observation meeting the criteria for comprehensive packing or the J2 Status Indicator. The J2 status indicator is defined as, "Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services." As this status indicator is not exempt this service is packaged. The insurance carrier's denial is supported.
- Procedure code 99285 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). As the submitted medical bill contains 26 hours of observation, the criteria for comprehensive packaging is met. 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 0.9756 for an adjusted labor amount of $1,375.49. The non-labor portion is 40% of the APC rate, or $939.93. The sum of the labor and non-labor portions is $2,315.42. The Medicare facility specific amount of $2,315.42 is multiplied by 200% for a MAR of $4,630.84.
- Procedure code 93306 has a status indicator of S. The medical bill contained codes 99285 and G0283 for 26 hours of observation meeting the criteria for comprehensive packing or the J2 Status Indicator. The J2 status indicator is defined as, "Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services." As this status indicator is not exempt this service is packaged. The carrier's denial is supported.
- Procedure code 93880 has a status indicator of S. The medical bill contained codes 99285 and G0283 for 26 hours of observation meeting the criteria for comprehensive packing or the J2 Status Indicator. The J2 status indicator is defined as, "Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services." As this status indicator is not exempt this service is packaged. The insurance carrier's denial is supported.

3. The total recommended reimbursement for the disputed services is $4,630.84. The insurance carrier paid $1,026.44. The amount due is $3,604.40. This amount is recommended.

Conclusion

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,604.40.

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 $3,604.40, 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 17, 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.