



# 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 OF DALLAS

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-19-0974-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 19, 2018

#### REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC: Please see included calculations for reimbursement of CPT 99285"

Amount in Dispute: \$3,602.09

#### RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payment is due for code 99285.... Texas Mutual believes the correct payment amount is \$1026.45."

Response Submitted by: Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 8, 2018	Outpatient Hospital Services: Evaluation Code 99285	\$3,602.09	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
  - 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)
  - 18 – EXACT DUPLICATE CLAIM/SERVICE
  - 715 – SERVICE PREVIOUSLY BILLED WITH DIFFERENT/INCORRECT CODES, PROVIDER, CLAIM, ETC. PROCESSED AS CORRECTION ONLY-NO ADDTNL PAYMENT.
  - 224 – DUPLICATE CHARGE.
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
  - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient hospital services subject to DWC’s *Hospital Facility Fee Guideline*, Rule §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors published in the Federal Register, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed 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](http://www.cms.gov).

Reimbursement is calculated as follows:

- Procedure code 99285 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). This code is assigned APC 5025. The OPPS Addendum A rate is \$520.85, multiplied by 60% for an unadjusted labor amount of \$312.51, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of \$304.88. The non-labor portion is 40% of the APC rate, or \$208.34. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of \$513.22. This is multiplied by 200% for a MAR of \$1,026.44.

The total recommended payment for the services in dispute is \$1,026.44. The insurance carrier paid \$1,026.45, leaving an amount due of \$0.00. No additional payment is 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

	Grayson Richardson	November 9, 2018
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. A party seeking review must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWCO45M) in accordance with the form’s instructions. The division must receive the request within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.