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
TX HEALTH STEPHENVILLE

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-1088-02

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by TX HEALTH STEPHEVILLE to audit their Workers Compensation claims. We have found this claim to be underpaid according the fee schedule as detailed in Rule 134.403 stating the fee schedule is 200% of the applicable Medicare payment regardless of billed amount."

Amount in Dispute: $2,165.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 2/16/2018. No additional payment is due for an outlier."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 16, 2018	Outpatient Hospital Services	$2,165.39	$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 acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 356 – The outpatient allowance was based on the medicare's methodology (PART B) Plus the Texas Markup
   - 370 – This Hospital outpatient allowance was calculated according to the APC rate, plus markup
   - 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS

- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 746 – Routine drug/alcohol, tests for emplyr & as part of emplyr policy are not reimbursable by the carrier
- 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 the 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 J7120 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure code L0120 has status indicator A, for services paid by fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the code on the date provided. Per DWC Professional Fee Guideline, Rule §134.203(d)(1), the facility fee is based on Medicare's Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee for this code of $24.08. 125% of this amount is $30.10
   - Procedure code 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code G0480 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 84484 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 83690 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 82550 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

- Procedure code 80307 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 80053 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85730 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85610 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 81001 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- 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 0.9437 for an adjusted labor amount of $294.92. The non-labor portion is 40% of the APC rate, or $208.34. The sum of the labor and non-labor portions is $503.26. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $503.26 is multiplied by 200% for a MAR of $1,006.52.
- Procedure code 96376 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code 96375 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $37.03, multiplied by 60% for an unadjusted labor amount of $22.22, in turn multiplied by the facility wage index of 0.9437 for an adjusted labor amount of $20.97. The non-labor portion is 40% of the APC rate, or $14.81. The sum of the labor and non-labor portions is $35.78 multiplied by 3 units is $107.34. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $107.34 is multiplied by 200% for a MAR of $214.68.
- Procedure code 96374 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.9437 for an adjusted labor amount of $108.20. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is $184.64. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $184.64 is multiplied by 200% for a MAR of $369.28.
- Procedure code J1885 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2270 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

- Procedure code J3010 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code Q9967 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure codes 74177, 72125, 70450, and 71260 have status indicator Q3, for packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast. If a "without contrast" CT and a "with contrast" CT are billed together, APC 8006 is assigned instead of APC 8005. If a composite includes multiple lines, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line in proportion to other separately paid services on the bill. This line is assigned status indicator S, for procedures not subject to reduction. This code is assigned APC 8006. The OPPS Addendum A rate is $500.85, multiplied by 60% for an unadjusted labor amount of $300.51, in turn multiplied by the facility wage index of 0.9437 for an adjusted labor amount of $283.59. The non-labor portion is 40% of the APC rate, or $200.34. The sum of the labor and non-labor portions is $483.93. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $483.93 is multiplied by 200% for a MAR of $967.86.

2. The total recommended reimbursement for the disputed services is $2,588.44. The insurance carrier paid $3,152.66. 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

		3/28/2019
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.

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.