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
TECHNOLOGY INSURANCE COMPANY

MFDR Tracking Number
M4-19-3273-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Appealing for the bundling of CPT code 49585 as it is the primary CPT code with status indicator J1 payable under the CMS allowable for the facility charges."

Amount in Dispute: $5,727.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment for CPT code 49585 is packaged within the payment for CPT code 49505."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 29, 2018	Outpatient Hospital Services	$5,727.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 351 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient facility 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(d) requires that for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in the rule.

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.

The provider is disputing procedure code 49585 only. This procedure was billed together with procedure code 49505, performed on the same date. Both services have payment status indicator J1, for procedures paid at a comprehensive rate. Medicare policy requires payment for all covered services on the bill be packaged with the primary "J1" procedure (except those with status F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). When two or more procedures on the bill are assigned status indicator J1, the code with the highest reimbursement is paid, and payment for all other services on the bill, including any other J1 procedures, is included in the reimbursement for the primary J1 procedure.

Review of the submitted documentation finds that procedure code 49505 is the primary comprehensive procedure on the bill. The insurance carrier issued payment to the provider of $5,695.16 for that code in accordance with Medicare policy regarding comprehensive APCs. Payment for all other services on the bill, including disputed code 49585, is packaged with the reimbursement for primary J1 service code 49505. Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

The amount remaining due to the requestor is $0.00. 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

	Grayson Richardson	March 22, 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 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.