



# 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 OF STEPHENVILLE

**Respondent Name**

OLD REPUBLIC INSURANCE COMPANY

**MFDR Tracking Number**

M4-19-3522-01

**Carrier's Austin Representative**

Box Number 44

**MFDR Date Received**

March 22, 2019

**Response Submitted By**

Helmsman

#### REQUESTOR'S POSITION SUMMARY

"Underpaid/denied APC"

#### RESPONDENT'S POSITION SUMMARY

"The bill has been reviewed and adjusted for payment – copies of EOBs are submitted for your review."

#### SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 9, 2018	Outpatient Hospital Services: CPT 20680	\$476.62	\$40.21

#### AUTHORITY

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

- 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:
  - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
  - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
  - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

#### 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, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors 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 hospital 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 for the disputed services is calculated as follows:

- Procedure code 20680 has status indicator Q2, for T-packaged codes; reimbursement is packaged with payment for any service with status indicator T. This code is paid separately only if OPPS criteria are met. This code is assigned APC 5073. The OPPS Addendum A rate is \$2,324.87, multiplied by 60% for an unadjusted labor amount of \$1,394.92, in turn multiplied by the facility wage index of 0.9592 for an adjusted labor amount of \$1,338.01. The non-labor portion is 40% of the APC rate, or \$929.95. The sum of the labor and non-labor portions is \$2,267.96. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$2,267.96 is multiplied by 200% for a MAR of \$4,535.92.
- Payment for all other services on the bill is packaged with the primary comprehensive J1 service per Medicare policy regarding comprehensive APCs. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details.

The total recommended reimbursement for the disputed services is \$4,535.92. The insurance carrier paid \$4,495.71. The amount due is \$40.21. This amount is recommended.

### Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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 \$40.21.

### **ORDER**

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor \$40.21, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

### Authorized Signature

_____	Grayson Richardson	_____
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. The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.