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 PLANO

Respondent Name
BITCO NATIONAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3865-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 22, 2019

Response Submitted By
Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"Bundling. COT 71260 Paid under OPPS Composite payment … Underpaid/denied APC. CPT 99285 Family 8011…"

RESPONDENT'S POSITION SUMMARY

"The carrier's position remains consistent with its EOB."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 11, 2018 to October 12, 2018	Outpatient Hospital Services	$4,623.49	$1,303.31

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

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:
   - 97 – Charge Included in another Charge or Service.
   - TC – Technical Component
   - GP – Service delivered under OP PT care plan
   - 25 – Separate E&M Service, Same Physician
   - P12 – Workers' Compensation State Fee Schedule Adj
   - W3 – 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 hospital facility services, unless separate payment of implantables is requested. Separate reimbursement for implants was not requested.

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 99285 has status indicator J2, for outpatient visits subject to comprehensive packaging if 8 or more hours observation is billed. More than 8 hours of observation (HCPCS G0378) was billed. Thus, Medicare criteria for comprehensive packaging are met. This code is assigned APC 8011 with OPPS Addendum A rate of $2,349.82, which is multiplied by 60% for an unadjusted labor amount of $1,409.89, and in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $1,372.67. The non-labor portion is 40% of the APC rate, or $939.93. 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 $2,312.60. This is multiplied by 200% for a MAR of $4,625.20.
- Payment for all other services on the bill is packaged with the primary comprehensive J2 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 $4,625.20. The insurance carrier paid $3,321.89. The amount due is $1,303.31. 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 established that additional reimbursement is due. As a result, the amount ordered is $1,303.31.

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 $1,303.31, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	May 16, 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.

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.