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 STEPHENVILLE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4495-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 14, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"CPT 97116: DOS Not Paid… CPT 9716: Underpaid/Denied APC… CPT 99284: Underpaid/Denied Physical Therapy Rate"

RESPONDENT'S POSITION SUMMARY

"Texas Mutual Insurance Company has elected to pay the disputed services for cpt code 97116… No additional payment is due for CPT code 97161 as it was paid appropriately…. Cpt code 99284 paid under OPPS/APC, per wage index 0.9592… the carrier issued payment in the amount $753.02 and appears an overpayment was made by the bill review system. No additional payment is due for 99284."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 28 - 29, 2019	Outpatient Hospital Services: CPT 97116, 97161, 99284	$3,824.83	$2,330.81

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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994
   - 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.

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 be multiplied by 200% for these 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.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 99284 has status indicator J2, for outpatient visits subject to comprehensive packaging if 8 or more hours observation billed. The provider billed more than 8 hours observation and Medicare criteria for comprehensive packaging are met. Accordingly, this code is assigned APC 8011, for comprehensive observation services. The OPPS Addendum A rate is $2,386.80, which is multiplied by 60% for an unadjusted labor amount of $1,432.08, and in turn multiplied by the facility wage index of 0.9592 for an adjusted labor amount of $1,373.65. The non-labor portion is 40% of the APC rate, or $954.72. 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 $2,328.37. This is multiplied by 200% for a MAR of $4,656.74.
- 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.

Rule §133.307(d)(2)(B) requires the response to include "a paper copy of all initial and appeal EOBs related to the dispute…"

Rule §133.307(d)(2)(D) requires the response to include "a copy of any pertinent medical records or other documents relevant to the fee dispute."

Rule §133.307(d)(1) states, "If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information."

The division notes the respondent's position statement asserts the carrier "has elected to pay the disputed services for cpt code 97116." However, the respondent did not submit any documentation to support that additional payment was issued or in what amount. In accordance with Rule §133.307, the findings in this decision are based on the information available at the time of review.

The total recommended reimbursement for the disputed services is $4,656.74.
Documentation was presented to support the insurance carrier paid $2,32.93.
The amount remaining due is $2,330.81. This amount is recommended.

Conclusion

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $2,330.81.

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 $2,330.81, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 12, 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.