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
BAPTIST ST. ANTHONY'S HEALTH

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-5119-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 2, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"CPT code was reimbursed in accordance with OPPS/APC fee guidelines."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 15, 2019	Outpatient Hospital Services	$469.56	$0.00

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.
   - 236 – THIS BILLING CODE IS NOT COMPATIBLE WITH ANOTHER BILLING CODE PROVIDED ON THE SAME DAY ACCORDING TO NCCI OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCHEDULE REQUIREMENTS.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 420 – SUPPLEMENTAL PAYMENT.
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

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.

Reimbursement for the disputed services is calculated as follows:

- HCPCS code A9585 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.
- CPT code 72128 represents a computed tomography (CT) service assigned APC 5522. The OPPS Addendum A rate is $112.51. This is multiplied by 60% for an unadjusted labor amount of $67.51, in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of $55.05. The non-labor portion is 40% of the APC rate, or $45.00. The sum of the labor and non-labor portions is the Medicare facility specific amount of $100.05. This is multiplied by 200% for a MAR of $200.10.
- Per Medicare policy regarding correct coding initiative (CCI) edits, CPT code 96374 may not be reported with code 72157 billed on the same claim. Reimbursement for this service is included with payment for CPT code 72157.
- CPT 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 $525.30, multiplied by 60% for an unadjusted labor amount of $315.18, in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of $257.00. The non-labor portion is 40% of the APC rate, or $210.12. The sum of the labor and non-labor portions is $467.12. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $467.12 is multiplied by 200% for a MAR of $934.24.
- CPT codes 72157, and 72158 have status indicator Q3, for packaged codes paid through a composite APC. These services 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 8008, for magnetic resonance imaging (MRI) services including contrast. The OPPS Addendum A rate is $855.60, this is multiplied by 60% for an unadjusted labor amount of $513.36, which is in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of $418.59. The non-labor portion is 40% of the APC rate, or $342.24. The sum of the labor and non-labor portions is the Medicare facility specific amount of $760.83. This is multiplied by 200% for a MAR of $1,521.66.

The total recommended reimbursement for the disputed services is $2,656.00. The insurance carrier paid $2,839.80 (with additional payment of $2.31 in interest). Further payment is not 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 above, the division finds the requestor has not established that additional payment is due.
As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 6, 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.