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
UT HEALTH ATHENS

Respondent Name
BITCO GENERAL INSURANCE CORP.

MFDR Tracking Number
M4-20-0278-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 30, 2019

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

REQUESTOR'S POSITION SUMMARY

"Per Texas Fee Schedule calculations, this bill has been underpaid."

RESPONDENT'S POSITION SUMMARY

"It is the carrier's position that the provider has already been reimbursed pursuant to the Medical Fee Guidelines."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 27, 2019	Outpatient Hospital Services	$546.29	$546.29

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 (DWC) in Title 28, Part 2 of the Texas Administrative Code.

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:
   - 03P – Included in another billed procedure
   - 25 – Separate E&M Service, Same Physician
   - 97 – Charge Included in another Charge or Service.
   - P12 – Workers' Compensation State Fee Schedule Adj.
   - RZ0 – Status Indicator: Q4 Packaged Lab service
   - XU – Unusual Non-Overlapping Service
   - P14 – Payment is included in another svc/procedure occurring on same day
   - 234 – This procedure is not paid separately.
   - 59 – Distinct Procedural Service
   - RN – Not paid under OPPS: services included in APC rate
   - TC – Technical Component
   - 18 – Duplicate claim/service
   - R1 – Duplicate Billing
   - 97A – Provider appeal

Findings

This dispute regards Emergency Room services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §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 28 TAC §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 is calculated as follows:

- Procedure code 36415, 80053, 83690, 85007, 85027, 85610, and 85730 have status indicator Q4, for packaged labs; reimbursement is included with payment for the other hospital services.
- Procedure code 71045 represents an x-ray service with status S (not subject to reduction). This service is assigned APC 5521. The OPPS Addendum A rate is $62.30, multiplied by 60% for an unadjusted labor amount of $37.38, in turn multiplied by the facility wage index of 0.8244 for an adjusted labor amount of $30.82. The non-labor portion is 40% of the APC rate, or $24.92. The sum of the labor and non-labor portions is the Medicare facility specific amount of $55.74. This is multiplied by 200% for a MAR of $111.48.
- Procedure code 72170, 73030, 73502, 12001 and 12011 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for other services on the bill assigned status indicators S, T or V.
- Procedure codes 71260, 72125, 72129, 72132, 74177, and 70450 have status indicator Q3 (packaged codes paid through a composite APC). Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. If any CT service in the composite is performed using a contrast agent, APC 8006 is assigned instead of APC 8005. These services are assigned APC 8006, for computed tomography (CT) including contrast. The OPPS Addendum A rate is $480.77. This is multiplied by 60% for an unadjusted labor amount of $288.46, in turn multiplied by the facility wage index of 0.8244 for an adjusted labor amount of $237.81. The non-labor portion is 40% of the APC rate, or $192.31. The sum of the labor and non-labor portions is the Medicare facility specific amount of $430.12. This is multiplied by 200% for a MAR of $860.24.
- Per Medicare's Correct Coding Initiative (CCI) policy, procedure code 96365 may not be billed with codes 71260, 12001 and 12011 on the same date. A modifier may be used to differentiate services. Separate payment is allowed if a modifier is used appropriately. The requestor used modifier XU. The medical records support the service as billed. Separate payment is thus allowed. This assigned APC is 5693 with OPPS Addendum A rate $187.18, multiplied by 60% for a labor amount of $112.31, multiplied by facility wage index 0.8244 to adjust the labor amount to $92.59. The non-labor share is 40% of the APC rate, or $74.87. The sum is the Medicare specific amount of $167.46. This is multiplied by 200% for a MAR of $334.92.
- Per Medicare's Correct Coding Initiative (CCI) policy, procedure code 96375 may not be billed with codes 71260, 12001 and 12011 on the same date. A modifier may be used to differentiate services. Separate payment is allowed if a modifier is used appropriately. The requestor used modifier XU. The medical records support the service as billed. Separate payment is thus allowed. The assigned APC is 5691 with OPPS Addendum A rate $37.88, multiplied by 60% for a labor amount of $22.73, multiplied by facility wage index 0.8244 to adjust the labor amount to $18.74. The non-labor share is 40% of the APC rate, or $15.15. The sum is $33.89, multiplied by 3 units is $101.67. The Medicare facility specific amount of $101.67 is multiplied by 200% for a MAR of $203.34.
- Procedure code 99285 represents an Emergency Room visit assigned APC 5025. The OPPS Addendum A rate is $525.30, which is multiplied by 60% for an unadjusted labor amount of $315.18, and in turn multiplied by the facility wage index of 0.8244 for an adjusted labor amount of $259.83. The non-labor portion is 40% of the APC rate, or $210.12. The sum of the labor and non-labor portions is the Medicare facility specific amount of $469.95. This is multiplied by 200% for a MAR of $939.90.
- Procedure code J2405 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.

The total recommended reimbursement for the disputed services is $2,449.88. The insurance carrier paid $1,893.93. The requestor is seeking additional reimbursement of $546.29. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC 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 requestor has not established that additional payment is due. As a result, the amount ordered is $546.29.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $546.29, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 31, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.