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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Providence Health Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-1871-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 25, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria."

Amount in Dispute: $545.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 3-4, 2013	Outpatient Hospital Services	$545.42	$545.42

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §133.20 sets out requirements for medical bill claim submission by health care providers.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC - 29 – The time limit for filing has expired
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05
   - 193 – Original payment decision is being maintained

Issues

1. Was the claim submitted timely?

2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on March 5, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. 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 insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier denied the disputed services as CAC – 29, "The time limit for filing has expired." Review of the submitted documentation (Providence Health Care dated August 27, 2013) finds the following;
    a. 07/17/13 note "account primary carrier changed to Texas Mutual"
    b. 07/17/13 note, "6/21/13 correspondence from Tx Mutual, requesting medical records for this date of service"
    c. 08/13/13 note, "Worker's Comp claim and/or corrected bill mailed"

    The carrier's denial is not supported therefore, the disputed services will be reviewed per applicable rules and fee guidelines.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
    - Procedure code 72072, date of service June 4, 2013, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0261, which, per OPPS Addendum A, has a payment rate of $70.84. This amount multiplied by 60% yields an unadjusted labor-related amount of $42.50. This amount multiplied by the annual wage index for this facility of 0.8475 yields an adjusted labor-related amount of $36.02. The non-labor related portion is 40% of the APC rate or $28.34. The sum of the labor and non-labor related amounts is $64.36. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $64.36. This amount multiplied by 200% yields a MAR of $128.72.
    - Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of $229.37. This amount multiplied by 60% yields an unadjusted labor-related amount of $137.62. This amount multiplied by the annual wage index for this facility of 0.8475 yields an adjusted labor-related amount of $116.63. The non-labor related portion is 40% of the APC rate or $91.75. The sum of the labor and non-labor related amounts is $208.38. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $208.38. This amount multiplied by 200% yields a MAR of $416.76.

5. The total allowable reimbursement for the services in dispute is $545.48. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $545.42. This amount is recommended.

Conclusion

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 $545.42.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $545.42, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December , 2014
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 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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.