



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Health of Arlington

Respondent Name

California Insurance Company

MFDR Tracking Number

M4-14-2688-01

Carrier's Austin Representative

Box Number 06

MFDR Date Received

May 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health of Arlington to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008..."

Amount in Dispute: \$670.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Notice of Medical Fee Dispute sent to carrier. However, no written position submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2013	Outpatient Hospital Services	\$670.98	\$669.29

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 785 – No separate reimbursement, items and/or services are packaged into the APC rate
 - 168 – Submitted documentation does not support the level of service billed
 - 255 – Please resubmit with a more appropriate CPT/HCPCS code that better reflects services documented

Issues

- Did the respondent support denial of disputed service?
- What is the applicable rule for determining reimbursement for the disputed services?
- 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. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "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." Accordingly, this decision is based on the available information.
2. 28 Texas Administrative Code §134.403(d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." Review of the submitted documentation finds that the requestor performed an emergency room visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99285 is "Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function." Review of the submitted medical documentation finds:
 - a. American medical Response Arlington Narrative; "31 yo M. weakness and dizziness. He is found at the GM plant, working as a contractor, sitting on the floor of their small building. He appears very weak and tired. He is awake and states he feels very weak and dizzy, cannot get up. ...He is assisted up and to the cot, very weak and unstable. He also states his hands and feet and numb and tingly.
 - b. Texas Health Arlington Memorial Hospital, Orders (page 9), Comments: Patient presents with: Weakness – weakness x 1 wk intermittent, today feeling light headed and dizzy, had near syncopal episode. Blood in stool – x 2 days bright red

The Division finds the medical record does support the level of service billed. The Carrier's decision is not supported. Therefore, the disputed services will be reviewed per applicable rules and fee guidelines.

2. 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.
3. 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 J7030 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75

- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.53. 125% of this amount is \$18.16
- Procedure code 82272 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.48. 125% of this amount is \$5.60
- Procedure code 82550 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.95. 125% of this amount is \$11.19
- Procedure code 82553 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.46. 125% of this amount is \$10.58
- Procedure code 84484 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$13.53. 125% of this amount is \$16.91
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.69. 125% of this amount is \$13.36
- Procedure code 81003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.09. 125% of this amount is \$3.86
- Procedure code 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPSS 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 0616, which, per OPSS Addendum A, has a payment rate of \$344.71. This amount multiplied by 60% yields an unadjusted labor-related amount of \$206.83. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$197.61. The non-labor related portion is 40% of the APC rate or \$137.88. The sum of the labor and non-labor related amounts is \$335.49. 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 \$335.49. This amount multiplied by 200% yields a MAR of \$670.98.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to

multiple-procedure discounting, paid under OPSS with separate APC payment. These services are classified under APC 0099, which, per OPSS Addendum A, has a payment rate of \$26.67. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.00. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$15.29. The non-labor related portion is 40% of the APC rate or \$10.67. The sum of the labor and non-labor related amounts is \$25.96. 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 \$25.96. This amount multiplied by 200% yields a MAR of \$51.92.

4. The total allowable reimbursement for the services in dispute is \$806.31. This amount less the amount previously paid by the insurance carrier of \$137.02 leaves an amount due to the requestor of \$669.29. 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 \$669.29.

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 \$669.29, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

July , 2014

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.