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
Houston Orthopedic & Spine Hospital

Respondent Name
Republic Lloyds Insurance Co

MFDR Tracking Number
M4-15-1818-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These labs are mandatory and are taken place before surgery can be done."

Amount in Dispute: $393.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per our Fee Schedule (FS) Team, based on how the provider billed, all charges should be denied as: This is a packaged item. Services or procedures included in the APC rate, but NOT paid separately."

Response Submitted by: Gallagher Basset Services, Inc, 11940 Jollyville Road, Suite 210-N, Austin, TX 78759

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2014	Outpatient Hospital Services	$393.61	$0.00

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. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – Original payment decision is being maintained

Issues

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

Findings

1. The Carrier states in their position statement, "This is a packaged item. Services or procedures included in the APC rate, but NOT paid separately." 28 Texas Administrative Code §134.403 (d) states, "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 MLN Matters® Number: MM8572 Related Change Request Number: CR 8572 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8572.pdf, "2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing Since the inception of the OPPS, OPPS hospitals were paid separately for clinical diagnostic laboratory tests or services (laboratory tests) provided in the hospital outpatient setting at Clinical Laboratory Fee Schedule (CLFS) rates. Beginning in CY 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the OPPS. The general rule for OPPS hospitals is laboratory tests should be reported on a 13X bill type. There are limited circumstances described below in which hospitals can separately bill for laboratory tests. For these specific situations CMS is expanding the use of the 14x bill type to allow separate billing and payment at CLFS rates for hospital outpatient laboratory tests. Laboratory tests may be (or must be for a non-patient specimen) billed on a 14X claim in the following circumstances: (1) Non-patient laboratory specimen tests; non-patient continues to be defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital; (2) Beginning in 2014, when the hospital only provides laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services during that same encounter; and (3) Beginning in 2014, when the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting. In this case the lab test would be billed on a 14X claim and the other hospital outpatient services would be billed on a 13X claim. It will be the hospital's responsibility to determine when laboratory tests may be separately billed on the 14X claim under these limited exceptions. In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPPS and should be billed on a 13X type of bill." Based on the above, the Carrier's position is supported.

2. 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 36415 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 86140 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 85025 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 85651 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.
3. The total allowable reimbursement for the services in dispute is $0.00. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March , 2015
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.