



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

Doctor's Hospital at Renaissance

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-15-3340-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: \$908.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Revenue codes 250 and 272 are packed under OPPS. Codes 82962 have an "N" status under Addendum B. Texas Mutual paid the MAR for code 88312 and 88305. Codes 99214 and 99213 have a "B" status under Medicare. The requestor billed this three different times. The requestor changed the 99214 codes to G0463 and then submitted the bill again. Texas Mutual received the bill 1/26/15, which made this bill untimely. No additional payment is due. "

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2014 through October 7, 2014	Outpatient Hospital Services	\$908.44	\$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

- 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 §133.20 sets out the claim submission guidelines for healthcare providers.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16 – Claim/service lacks information or has submission/billing error(s)
 - 18 – Exact duplicate claim/service

- 224 – Duplicate charge
- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 370 – The hospital outpatient allowance was calculated according to the APC rate plus a markup
- 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 714 – Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly. Corrections must be submitted W/I 95 days from DOS
- 193 – Original payment decision is being maintained
- 29 – The time limit for filing has expired

Issues

1. Was the corrected bill 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 carrier denied the submitted codes 99214 as 618 – “The value of this procedure is packaged into the payment of other services performed on the same date of service” and 714 – “Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly. Corrections must be submitted within 95 days from DOS. The carrier also denied the corrected code G0463 as 29 – “The time limit for filing has expired.” Review of the submitted documentation from respondent finds;
 - a. Bill submission on October 7, 2014 indicates submitted code 99214 for dates of service September 2, 2014, September 16, 2014, September 23, 2014, and September 30, 2014
 - b. Bill submission on October 14, 2014 indicates submitted code 99214 for dates of service September 2, 2014, September 16, 2014, September 23, 2014, and September 30, 2014 and code 99213 for date of service October 7, 2014
 - c. Bill submission on November 24, 2014, indicates submitted code 99214 for dates of service September 2, 2014, September 16, 2014, September 23, 2014, and September 30, 2014 and code 99213 for date of service October 7, 2014
 - d. Bill submission on January 14, 2015, indicates submitted code G0463 for dates of service September 2, 2014, September 16, 2014, September 23, 2014, and September 30, 2014 and October 7, 2014

28 Texas Administrative Code §133.20 (c) states in pertinent part, “A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

28 Texas Administrative Code §133.20 (b) states, “Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.”

The Division finds the carrier’s denials are supported.

2. 28 Texas Administrative Code §134.403 states in pertinent part (f) The reimbursement calculation used for establishing the 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. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent;

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

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 82962, date of service September 2, 2014, 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 82962, date of service September 16, 2014, 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 82962, date of service September 30, 2014, 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 88342, date of service September 2, 2014, has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code 88312, date of service September 2, 2014, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0342, which, per OPPS Addendum A, has a payment rate of \$19.84. This amount multiplied by 60% yields an unadjusted labor-related amount of \$11.90. This amount multiplied by the annual wage index for this facility of 0.8426 yields an adjusted labor-related amount of \$10.03. The non-labor related portion is 40% of the APC rate or \$7.94. The sum of the labor and non-labor related amounts is \$17.97. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$17.97. This amount multiplied by 200% yields a MAR of \$35.94.
- Procedure code 88305, date of service September 2, 2014, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0433, which, per OPPS Addendum A, has a payment rate of \$36.53. This amount multiplied by 60% yields an unadjusted labor-related amount of \$21.92. This amount multiplied by the annual wage index for this facility of 0.8426 yields an adjusted labor-related amount of \$18.47. The non-labor related portion is 40% of the APC rate or \$14.61. The sum of the labor and non-labor related amounts is \$33.08. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$33.08. This amount multiplied by 200% yields a MAR of \$66.15.
- Procedure code 99214, date of service September 2, 2014, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99214, date of service September 16, 2014, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99214, date of service September 23, 2014, has a status indicator of B, which denotes

codes that are not recognized by OPSS when submitted on an outpatient hospital bill. Reimbursement is not recommended.

- Procedure code 99214, date of service September 30, 2014, has a status indicator of B, which denotes codes that are not recognized by OPSS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99213. Date of service October 7, 2014, has a status indicator of B, which denotes codes that are not recognized by OPSS when submitted on an outpatient hospital bill. Reimbursement is not recommended.

4. The total allowable reimbursement for the services in dispute is \$102.09. This amount less the amount previously paid by the insurance carrier of \$102.09 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

_____	_____	July , 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.