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
Central Texas Medical Center

Respondent Name
Great Midwest Insurance Co

MFDR Tracking Number
M4-15-3796-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TX law states reimbursement should be made per fee schedule allowance *regardless of billed amount*. Moreover, no line items were identified as unrelated or denied if this is the reason for no payment; thus carrier would still be violation of state requirements."

Amount in Dispute: $4,311.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOBs raise underlying issues of causal relation. In particular, the EOBs indicate that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2014	29881	$4,311.34	$4,162.60

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 acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - PS – The charge exceeds the APC rate for this service
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- P15 – Workers' compensation medical treatment guideline adjustment

Issues

1. Did the requestor raise a new issue with their response?
2. What is the applicable rule for determining reimbursement for the disputed service?
3. What is the recommended payment amount for the service in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states in their position statement, "The EOBs raise underlying issues of causal relation. In particular, the EOBs indicate that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury." The only code in dispute is 29881. The explanation of benefits submitted with this dispute show only PS, P12, P15 remark codes associated with this claim line. No remark code denying for causal relation were found. Per 28 Texas Administrative Code §133.307 (d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section." The respondent's position was not found on the explanation of benefits and therefore will not be considered in this review.
2. This dispute relates to outpatient hospital facility services 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 29881 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,155.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,293.40. This amount multiplied by the annual wage index for this facility of 0.9425 yields an adjusted labor-related amount of $1,219.03. The non-labor related portion is 40% of the APC rate or $862.27. The sum of the labor and non-labor related amounts is $2,081.30. 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 $2,081.30. This amount multiplied by 200% yields a MAR of $4,162.60.

4. The total allowable reimbursement for the services in dispute is $4,162.60. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $4,162.60. 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 $4,162.60.

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 $4,162.60 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September , 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 MFDR 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.