



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS HEALTH OF DALLAS

Respondent Name

AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number

M4-16-1866-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "they have not paid what we determine is the correct allowable per the APC allowable per the APC allowable per the new fee schedule that started 3/01/2008 . . . HCPS's are payable at 200% of the correct fee schedule allowable. Also, we realize this is has a status of Q3 but it is not bundled per the NCCI edits and they should have processed for a payment."

Amount in Dispute: \$189.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that ti ahs paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2015	Outpatient Hospital Services	\$189.10	\$103.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 acute care hospital fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
 - BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

- 7652 – 7652
- P300 – P300
- 97 – 97
- MX60 – MX60
- MSIN - MSIN

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 additional reimbursement?

Findings

1. This dispute regards 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 was not requested.

2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

- Procedure code 72170 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. However, there were other such procedures billed for the same date; therefore, payment for this procedure is packaged with the payment for other services performed.
- Procedure codes 72125, 70450 and 73700 represent CT services (without contrast) with status indicator Q3 denoting conditionally packaged codes paid under composite APC 8005 if OPPS criteria are met. These services meet the criteria for composite payment. Services assigned to composite APCs are major components of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. The payment for composite services is calculated below.
- Procedure code 96372 has status indicator S denoting a significant procedure not, subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of \$53.54. This amount multiplied by 60% yields an unadjusted labor-related amount of \$32.12. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related share of \$30.55. The non-labor related portion is 40% of the APC rate or \$21.42. The sum of the labor and non-labor related amounts is \$51.97. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,775. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$51.97. This amount multiplied by 200% yields a MAR of \$103.94.

- Procedure code 99284 has status indicator Q3 denoting conditionally packaged codes that may be paid as a composite APC. If OPPS criteria are met, this service is assigned to critical care composite APC 8009; however, in this claim, criteria for composite payment have not been met; therefore, this line is paid separately and assigned status indicator V denoting a clinic or emergency department visit. This evaluation and management service is classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$333.80. This amount multiplied by 60% yields an unadjusted labor-related share of \$200.28. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$190.51. The non-labor related portion is 40% of the APC rate or \$133.52. The sum of the labor and non-labor related amounts is \$324.03. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,775. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$324.03. This amount multiplied by 200% yields a MAR of \$648.06.
 - Procedure code J2270 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code Q0162 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure codes 72125, 70450, and 73700 have status indicator Q3 denoting conditionally packaged paid under composite APC 8005, for computed tomography (CT) services without contrast. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the claim. This line is assigned status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8005, which, per OPPS Addendum A, has a payment rate of \$313.37. This amount multiplied by 60% yields an unadjusted labor-related amount of \$188.02. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$178.84. The non-labor related portion is 40% of the APC rate or \$125.35. The sum of the labor and non-labor related amounts is \$304.19. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,775. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$304.19. This amount multiplied by 200% yields a MAR of \$608.38.
3. The total allowable reimbursement for the services in dispute is \$1,360.38. This amount less the amount previously paid by the insurance carrier of \$1,256.44 leaves an amount due to the requestor of \$103.94. 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 \$103.94.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$103.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	March 31, 2016
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.