



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

Northwest Texas Hospital

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-16-3160-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier denied the initial billing 11/02/2015 for corrected coding required. Need ICD-10 codes. The corrected claim was billed 12/08/2015 and 01/13/2016."

Amount in Dispute: \$454.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on June 23, 2016. 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), "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."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2015	Outpatient Hospital Services	\$454.06	\$454.06

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 reimbursement guidelines for services provided in outpatient hospital services.
- 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission by health care

provider.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which 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...” The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPSS services which are:

1. **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf,
To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.
2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPSS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPSS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPSS Addenda, Addendum D1.
3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPSS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the applicable fee pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the services in dispute as 29 – “The time limit for filing has expired.” 28 Texas Administrative Code §133.20 (b) states in pertinent part,

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.

Review of the submitted medical claim, box 23 finds the date, 12/08/15. The requestor states in their position statement, “The corrected claim was billed 12/08/2015 and 01/13/2016.” The respondent presented no evidence in rebuttal of this statement. Therefore, the services in dispute will be reviewed per applicable fee guidelines.

2. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

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 (OPSS) 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;

The services in dispute are reimbursed based on the following:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index/0.8074	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
96372	S	437	\$53.54	\$53.54 X 60% = \$32.12	\$32.12 X 0.8074 = \$25.93	\$53.54 X 40% = \$21.42	\$25.93 + \$21.42 = \$47.35	\$47.35 X 200% = \$94.70
99284	V	615	\$333.80	\$333.80 X 60% = \$200.28	\$200.28 X 0.8074 = \$161.71	\$333.80 X 40% = \$133.52	\$161.71 + \$133.52 = \$295.23	\$295.23 X 200% = \$590.46
							Total	\$685.16

The remaining service in dispute is reviewed as follows:

- Procedure code J1885 has status indicator N denoting packaged items and services with no separate APC payment.

3. The maximum allowable reimbursement for the eligible service is \$685.16. The requestor is seeking \$454.06. 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 \$454.06.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$454.06 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

August , 2016
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, 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.