



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

Texoma Medical Center

Respondent Name

Trumbull Insurance Co

MFDR Tracking Number

M4-16-3511-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

July 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please submit this claim for the correct allowable per ASC Rule 134:402:Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: \$53.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on July 21, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. 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." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 27, 2015, 90471, 99284, \$53.44, \$53.44

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

- 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 reimbursement guidelines for services provided in outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 105 – Additional information needed to review charges
 - P12 – Workers’ Compensation State fee schedule adj
 - 16 – Svc lacks info needed or has billing error(s)
 - 25 – Separate E&M service, Same Physician
 - B13 – Payment for service may have been previously paid

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.
4. **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Issues

1. What is the applicable fee pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 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 remaining 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/0.9572	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
90471	S	0437	\$53.54	$\$53.54 \times 60\% = \32.12	$\$32.12 \times 0.9572 = \30.75	$\$53.54 \times 40\% = \21.42	$\$30.75 + \$21.42 = \$52.17$	$\$52.17 \times 200\% = \104.34
99284	Q3	0615	\$333.80	$\$333.80 \times 60\% = \200.28	$\$200.28 \times 0.9572 = \191.71	$\$333.80 \times 40\% = \133.52	$\$191.71 + \$133.52 = \$325.23$	$\$325.23 \times 200\% = \$650.46 =$
							Total	\$754.80

2. The maximum allowable reimbursement for the eligible service is \$754.80. The carrier paid \$698.55. The requestor is seeking \$53.44. 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 \$53.44.

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 \$53.44, 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.