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
Texas Health of Plano

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-18-0970-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 6, 2017

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 allowance. Please note per the NCCI Edits this line is not bundled and we show should have processed for payment as there are not S. T U or V status indicators used for the code to be bundled with."

Amount in Dispute: $107.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is seeking additional reimbursement of $107.75. However, the carrier's position is that the billing for that service is already included in another service and thus, the provider is seeking to unbundle services. The carrier's position is that the provider is not entitled to any additional reimbursement other than that identified on the August 7, 2017 EOB."

Response Submitted by: Flahive, Ogden and Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 2, 2017	Outpatient Hospital Services	$107.75	$0.00

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 acute care hospital fee guideline for outpatient services.

3. 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

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking additional reimbursement in the amount of $107.75 for outpatient hospital services rendered on May 2, 2017. The insurance carrier denied disputed services with claim adjustment reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.403 (d) 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 with any additions or exceptions specified in this section, including the following paragraphs.

   The requestor states "…this line is not bundled and we show should have processed for payment as there are not S, T, U or V status indicators used for the code to be bundled into."

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 71020 has status indicator Q3, denoting conditionally packaged codes paid as a composite if OPPS criteria are met. As packaging criteria were not met, this line is separate and has a status indicator of S. This is assigned APC 5521. The OPPS Addendum A rate is $59.86, which is multiplied by 60% for an unadjusted labor-related amount of $35.92, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $35.18. The non-labor related portion is 40% of the APC rate, or $23.94. The sum of the labor and non-labor portions is $59.12. The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0. The Medicare facility specific amount of $59.12 is multiplied by 200% for a MAR of $118.24.
   - Procedure code 99283 has status indicator J2, denoting hospital, clinic or emergency room visits (including observation/critical care services) subject to composite payment if certain other services are billed in combination. As the composite criteria is not met, the status indicator is V. This is assigned APC 5023. The OPPS Addendum A rate is $201.25, which is multiplied by 60% for an unadjusted labor-related amount of $120.75, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $118.26. The non-labor related portion is 40% of the APC rate, or $80.50. The sum of the labor and non-labor portions is $198.76. The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0. The Medicare facility specific amount of $198.76 is multiplied by 200% for a MAR of $397.52.
   - Procedure code 93005 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V. This code is paid separately only if OPPS criteria are met.

Based on the applicable Medicare payment policy, additional payment is not 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 29, 2017
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 Rule §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. **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.