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
TX HEALTH ROCKWALL

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-18-3365-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We appealed the initial payment of this bill and it remains underpaid per Texas Fee Schedule."

Amount in Dispute: $3,597.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the billed amount was less than the amount paid; yet the provider is seeking additional reimbursement under CPT code 24685-XP-RT . . . less implants paid in the amount of $246.40, . . . The carrier has paid the provider consistent with the Medical Fee Guidelines."

Response Submitted by: Flahive, Odgen & Latson, Attorneys At Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 5, 2018	Outpatient Hospital Services	$3,597.94	$3,597.94

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

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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set out in the rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200 percent for the disputed outpatient surgery services, unless a facility or surgical implant provider requests separate payment of implantables. However, review of the submitted documentation finds that separate reimbursement for implants was not requested.

   The respondent's position statement asserts, "implants paid in the amount of $246.40"; however, despite the invoice containing a signed certification as to the true and correct actual cost of the implanted items, the division finds no evidence the hospital elected to receive separate reimbursement for implants. There was no request on the bill or in the accompanying medical records or appeal letter.

   Moreover, Rule §133.10(f)(2)(QQ), regarding the division's required billing forms and formats, requires that "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested." Review of the submitted UB-04 medical billing form finds that Remarks field 80 contains no indication that separate reimbursement of implants was requested.

   The adoption preamble to the Outpatient hospital fee guideline is clear that the choice to request separate reimbursement of implantables lies with the medical provider, not the insurance carrier.

   Furthermore, the plain language of the rule is clear that, in the absence of such a request, the default payment should be the Medicare facility specific reimbursement (including outlier payments) multiplied by 200%.

   Consequently, the division will review the disputed services for payment at the 200% rate (inclusive of implants) pursuant to Rule §134.403(f)(1)(A).

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Please note: Rule §134.403(e)(2) specifies that the maximum allowable reimbursement (MAR) amount under subsection (f) (including payment for outliers and implants) is to be paid *regardless of billed amount*. Therefore, the billed amount is not relevant to determining the payment due for the services in this dispute.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 24685 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on this bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is $5,606.42, multiplied by 60% for an unadjusted labor amount of $3,363.85, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $3,281.77. The non-labor portion is 40% of the APC rate, or $2,242.57. The sum of the labor and non-labor portions is $5,524.34. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $5,524.34 is multiplied by 200% for a MAR of $11,048.68.
   - Payment for all other services on the bill is packaged with the primary comprehensive J1 service according to Medicare policy regarding comprehensive APCs. Reimbursement for all items is included in the payment for the primary procedure. Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

2. The total recommended reimbursement for the disputed services is $11,048.68. The insurance carrier paid $7,428.04. The requestor is seeking additional reimbursement of $3,597.94. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 $3,597.94.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $3,597.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 3, 2018
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.