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 Plano

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-18-3447-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
May 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We respectfully ask that you reprocess this line item charge at the correct APC allowable at 200% per the appropriate fee schedule of 3/01/2008, minus their previous payment."

Amount in Dispute: $320.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill has already been reimbursed at the correct amount."

Response Submitted by: White Espey PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2107	Outpatient Hospital Services	$320.10	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered on August 10, 2017. The insurance carrier reduced the billed amount with claim adjustment reason codes associated with fee schedules adjustment. 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 (OPPS) 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 applicable fee guideline calculation below is made based on these guidelines to verify the carrier's reduction(s) were appropriate.

2. 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 36415 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 80053 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 85025 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 70200 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
   - Procedure code 74175 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8006. The payment for composite services is calculated below.
   - Procedure code 71275 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8006. The payment for composite services is calculated below.
   - Procedure code 99285 has status indicator J2, denoting outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed) however since the comprehensive packaging criteria is not met, this code is assigned APC 5025 with a status indicator of V. The OPPS Addendum A rate is $488.74. This is multiplied by 60% for an unadjusted labor-related amount of $293.24, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $287.20. The non-labor related portion is 40% of the APC rate, or $195.50. The sum of the labor and non-labor portions is $482.70. The Medicare facility specific amount of $482.70 is multiplied by 200% for a MAR of $965.40.
   - Procedure code 96376 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.

- Procedure code 96375 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $34.78. This is multiplied by 60% for an unadjusted labor-related amount of $20.87, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $20.44. The non-labor related portion is 40% of the APC rate, or $13.91. The sum of the labor and non-labor portions is $34.35. The Medicare facility specific amount of $34.35 is multiplied by 200% for a MAR of $68.70.
- Procedure code 96374 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $179.77. This is multiplied by 60% for an unadjusted labor-related amount of $107.86, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $105.64. The non-labor related portion is 40% of the APC rate, or $71.91. The sum of the labor and non-labor portions is $177.55. The Medicare facility specific amount of $177.55 is multiplied by 200% for a MAR of $355.10.
- Procedure code 72148 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 is assigned APC 5523. The OPPS Addendum A rate is $225.91. This is multiplied by 60% for an unadjusted labor-related amount of $135.55, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $132.76. The non-labor related portion is 40% of the APC rate, or $90.36. The sum of the labor and non-labor portions is $223.12. The Medicare facility specific amount of $223.12 is multiplied by 200% for a MAR of $446.24.
- Procedure code Q9967 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2405 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J1170 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J1100 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure codes 74175, and 71275 have status indicator Q3, denoting packaged codes paid through a composite APC. These services are assigned composite APC 8006, this line is assigned status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 8006. The OPPS Addendum A rate is $489.37. This is multiplied by 60% for an unadjusted labor-related amount of $293.62, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $287.57. The non-labor related portion is 40% of the APC rate, or $195.75. The sum of the labor and non-labor portions is $483.32. The Medicare facility specific amount of $483.32 is multiplied by 200% for a MAR of $966.64.

3. The total allowable reimbursement for the disputed services is $2,802.08. The insurance carrier paid $3,225.87. The amount due is $0.00. 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

Signature	Medical Fee Dispute Resolution Officer	June 13, 2018 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.