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
LAREDO MEDICAL CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-18-3608-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: $83.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains that it calculation is correct and that additional reimbursement is not owed."

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 9, 2017	Outpatient Hospital Services	$83.55	$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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED.
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
   - 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
   - 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

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 Emergency Visit services.

   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.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes 36415, 80047, 80076, 82550, 82553, 83874, 83880, 84484, 85025, 85610 and 85730 have status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 71120 and 93005 have status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for procedure code 96374, a status S procedure performed on the same date.
   - Procedure code 71010 has status indicator Q3, denoting conditionally packaged codes. As packaging criteria were not met, this line is paid separately under assigned APC 5521. The OPPS Addendum A rate is $59.86, which is multiplied by 60% for an unadjusted labor amount of $35.92, multiplied by the facility wage index of 0.7767 for an adjusted labor amount of $27.90. The non-labor portion is 40% of the APC rate, or $23.94. The sum of the labor and non-labor portions is $51.84. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $51.84 is multiplied by 200% for a MAR of $103.68.
   - Procedure code 71260 has status indicator Q3, denoting conditionally packaged codes. As packaging criteria were not met, this line is paid separately under assigned APC 5571. The OPPS Addendum A rate is $265.02, which is multiplied by 60% for an unadjusted labor amount of $159.01, multiplied by the facility wage index of 0.7767 for an adjusted labor amount of $123.50. The non-labor portion is 40% of the APC rate, or $106.01. The sum of the labor and non-labor portions is $229.51. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $229.51 is multiplied by 200% for a MAR of $459.02.
   - 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, multiplied by 60% for an unadjusted labor amount of $107.86, in turn multiplied by the facility wage index of 0.7767 for an adjusted labor amount of $83.77. The non-labor related portion is 40% of the APC rate, or $71.91. The sum of the labor and non-labor portions is $155.68. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $155.68 is multiplied by 200% for a MAR of $311.36.
   - Procedure code 99284 has status indicator J2, denoting outpatient visits. This code is assigned APC 5024. The OPPS Addendum A rate is $332.41, multiplied by 60% for an unadjusted labor amount of $199.45, in turn multiplied by the facility wage index of 0.7767 for an adjusted labor amount of $154.91. The non-labor portion is 40% of the APC rate, or $132.96. The sum of the labor and non-labor portions is $287.87. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $287.87 is multiplied by 200% for a MAR of $575.74.

2. The total allowable reimbursement for the disputed services is $1,449.80. The insurance carrier paid $1,449.80. The amount due is $0.00. No additional payment 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 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

	Grayson Richardson	June 22, 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.