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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-18-4949-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate. . . . reimbursement should be $8,583.29."

Amount in Dispute: $3,836.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company stands on their original review regarding date of service 5/8/2018. . . . Fee Schedule review has determined the bill was priced correctly"

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 8, 2018	Outpatient Hospital Services	$3,836.29	$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:
   - 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.
   - MOPS – services reduced to the Outpatient Prospective Payment System (OPPS)
   - Z652 - Recommendation of payment has been based on a procedure code that best describes the services rendered.
   - 96 – NON-COVERED CHARGE(S).
   - P300 – The amount paid reflects a fee schedule reduction.
   - MJ1N – Recommended reimbursement is based on CMS Hospital Outpatient status indicator J1: Comprehensive APC Non-Complexity Adjustment.

- 00950 – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.
- W3 – Request for reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

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 subject to DWC's *Hospital Facility Fee Guideline*, Rule §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 published in the Federal Register, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed facility 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 code 26952 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (with certain exceptions not present on this bill). This code is assigned APC 5113. The OPPS Addendum A rate is $2,645.23, multiplied by 60% for an unadjusted labor amount of $1,587.14, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $1,315.58. The non-labor portion is 40% of the APC rate, or $1,058.09. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $2,373.67. This is multiplied by 200% for a MAR of $4,747.34.
   - Procedure code 11012 also has status indicator J1. Per Medicare policy only the J1 code with the highest value is paid. Payment for all other services on the bill is included with payment for the primary procedure. Separate payment for this code is not recommended.
   - 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 $4,747.34. The insurance carrier paid $4,747.34. Additional payment is not 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 evidence presented by the requestor and respondent available 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	September 28, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.