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
LA JOYA INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-18-5048-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
August 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we have concluded that reimbursement received was inaccurate. Based on CPT Code 29888, allowed amount of $5,030.51, multiplied at 200%, CPT Code 29881, allowed for $1186.75, multiplied at 200% x .5, and CPT code 96374, allowed amount of $171.46, multiplied at 200% reimbursement should be $12,777.44. Payment received was only $10,061.73 . . . there is a pending payment in the amount of $2,715.71."

Amount in Dispute: $2,715.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier will stand on the denial/reduction . . . status indicator J1 is associated with procedure code 29888. All covered Part B services on the claim are packaged with the primary 'J1' service"

Response Submitted by: Dean G. Pappas, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 9, 2018 to May 10, 2018	Outpatient Hospital Services	$2,715.71	$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.
   - P15 – Workers' Compensation Medical Treatment Guideline Adjustment
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 16 – Claim/service lacks information or has submission/billing error(s)
- 96 – Non-covered charge(s).
- PJ – This code is not paid under outpatient PPS.
- PN – This service is considered incidental, packaged or bundled into another service or APC payment.
- ZG - Your billing has been paid in accordance with the Inpatient Hospital Fee Schedule or the Outpatient Fee Schedule.

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 published 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 these disputed outpatient 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 29888 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the 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 0.8289 for an adjusted labor amount of $2,788.30. The non-labor portion is 40% of the APC rate, or $2,242.57. The sum of the labor and non-labor portions is the Medicare facility specific amount of $5,030.87. The cost of services does not exceed the threshold for outlier payment. The sum of $5,030.87 is multiplied by 200% for a MAR of $10,061.74.
   - 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 $10,061.74. The insurance carrier paid $10,061.73. 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 7, 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.