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
TEXAS HEALTH HEB

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-19-2836-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 22, 2019

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $2,585.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is believed that the provider is rounding up the wage index of 0.9636 in calculating the amount due."

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 10, 2018	Outpatient Hospital Services	$2,585.66	$53.86

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.
   - OA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUNDLING OF SERVICES.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The hospital seeks additional reimbursement for procedure code 49565. The respondent's position statement asserts, "It is believed that the provider is rounding up the wage index of 0.9636 in calculating the amount due."

DWC *Hospital Facility Fee Guideline* Rule §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in the rule.

Rule §134.403(d)(3) further requires that "Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date…"

The division notes that the wage index for this facility on the date of service was 0.9736 — not 0.9636, which was the previous wage index for this facility, effective during Medicare's fiscal year 2018. However, service date October 10, 2018 falls within Medicare's fiscal year 2019.

While many of the formulas and factors of Medicare's Outpatient Prospective Payment System (OPPS) become effective with the calendar year (CY 2018: from January 1, 2018 to December 31, 2018), Medicare's wage index factors are updated and become effective with Medicare's *fiscal year* (FY 2019: from October 1, 2018 through September 30, 2019). The disputed service date is October 10, 2018. This falls within Medicare's fiscal year FY 2019 (effective October 1, 2018). Medicare wage index information (including effective dates) are available from the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html

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 OPPS formulas and factors modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for these 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 49565 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is assigned APC 5361. The OPPS Addendum A rate is $4,488.68, which is multiplied by 60% for an unadjusted labor amount of $2,693.21 and multiplied in turn by the facility wage index of 0.9736 for an adjusted labor amount of $2,622.11. The non-labor portion is 40% of the APC rate, or $1,795.47. The sum of the labor and non-labor portions is $4,417.58. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $4,417.58 is multiplied by 200% for a MAR of $8,835.16.
- 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.

The total recommended reimbursement for the disputed services is $8,835.16. The insurance carrier paid $8,781.30. The amount due is $53.86. This amount is recommended.

Conclusion

For the reasons stated above, the division finds the requestor has established that additional reimbursement is due. As a result, the amount ordered is $53.86.

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 $53.86, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	February 15, 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.