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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-2928-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
January 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "authorization was obtained on 08/24/2018 auth# 116413…"

Amount in Dispute: $2,762.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the facility did not bill for the procedure codes and/or services that were preauthorized."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 30, 2018	Outpatient Hospital Services	$2,762.22	$2,419.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 6545 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Was precertification/authorization absent?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 6545 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT

   The submitted documentation supports that the hospital requested preauthorization for the disputed services. The documentation also supports that the carrier's utilization review agent approved the request.

   The submitted Preauthorization Determination Letter states: "IMO has preauthorized medical necessity for Surgery: Removal of Hardware x 2 Pins Left Hand/Small Finger."

   The primary procedure code billed was CPT 26320, defined as "Removal of implant from finger or hand."

   The division finds the services performed were consistent with the utilization review determination as approved. The division therefore concludes that preauthorization/certification was not absent.

   The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with division fee guidelines.

2. This dispute regards outpatient hospital 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 modified by division rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed outpatient surgical 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 26320 is assigned APC 5072 which has payment status indicator J1 for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. The OPPS Addendum A rate is $1,348.03. This is multiplied by 60% for an unadjusted labor amount of $808.82, and in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $670.43. The non-labor portion is 40% of the APC rate, or $539.21. 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 $1,209.64. This is multiplied by 200% for a MAR of $2,419.28.
   - Payment for all other services on the bill is packaged with the primary comprehensive J1 service per Medicare policy regarding comprehensive APCs. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details.

   The total recommended reimbursement for the disputed services is $2,419.28. The insurance carrier paid $0.00. The amount due is $2,419.28. This amount 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 findings in this decision are based on the evidence 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 established that additional reimbursement is due. As a result, the amount ordered is $2,419.28.

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 $2,419.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 24, 2019
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.