



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

HIDALGO COUNTY

MFDR Tracking Number

M4-19-3762-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

April 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "reimbursement received was inaccurate...pending payment in the amount of \$868.54."

Amount in Dispute: \$1,097.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was...paid per the Fee Schedule for services bundled in the total facility payment."

Response Submitted by: IMO, Injury Management Organization, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 18, 2019 to January 21, 2019	Outpatient Hospital Services	\$1,097.54	\$0.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 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.
 - 797 – SERVICE NOT PAID UNDER MEDICARE OPPTS.
 - 96 – NON-COVERED CHARGE(S).
 - 97 – PAYMENT ADJUSTED BECAUSE 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.
 - 18 – DUPLICATE CLAIM/SERVICE
 - 18 – EXACT DUPLICATE CLAIM/SERVICE
 - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE
 - 306 – BILLING IS A DUPLICATE OF OTHER SERVICES PERFORMED ON SAME DAY
 - B20 – PAYMENT ADJUSTED BECAUSE PROCEDURE/SERVICE WAS PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER.

Issues

Is the requestor entitled to additional reimbursement?

Findings

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 23120 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on this bill are packaged with the primary "J1" procedure. This code is assigned APC 5113 with an OPPS Addendum A rate of \$2,623.34. This is multiplied by 60% for an unadjusted labor amount of \$1,574.00, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of \$1,294.46. The non-labor portion is 40% of the APC rate, or \$1,049.34. 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 amount of \$2,343.80. This is multiplied by 200% for a MAR of \$4,687.60.
- 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.

Total reimbursement for the services is \$4,687.60. The carrier paid \$4,687.60. No additional payment 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.

The division finds the requestor has not established that additional payment is due. 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	April 25, 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 DWCO45M) 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.