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
M4-19-3942-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
April 26, 2019

Response Submitted By
State Office of Risk Management

REQUESTOR'S POSITION SUMMARY

"After reviewing the account we have concluded that reimbursement received was inaccurate… there is a pending payment in the amount of $1,167.32."

RESPONDENT'S POSITION SUMMARY

"The Office did find that additional payment is owed for CPT code(s) 70450 (APC 8005), 72125 (APC 8005), 71260 (APC 8006), 74177 (APC 8006) … The Office will request an immediate re-audit to allow additional payment…"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 19, 2018	Outpatient Hospital Services	$1,167.32	$0.00

AUTHORITY

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 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.
   - 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.
   - 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

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 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 96360 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $94.29. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is the Medicare facility specific amount of $170.73. This is multiplied by 200% for a MAR of $341.46.
- Procedure codes 36415, 80048, G0480, 85025, 85610, 85730 have status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 7217, 73590, 73120, 73590 and 90471 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for procedure code 96360.
- Procedure code 71045 represents a chest x-ray with status indicator Q3. As packaging criteria are not met, this line is separately paid. This line is assigned APC 5521 with OPPS Addendum A rate of $62.12. This is multiplied by 60% for an unadjusted labor amount of $37.27, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $30.65. The non-labor portion is 40% of the APC rate, or $24.85. The sum of the labor and non-labor portions is the Medicare facility specific amount of $55.50. This is multiplied by 200% for a MAR of $111.00.
- Procedure code 99285 has status indicator J2, for outpatient visits. No observation services were billed; criteria for composite payment are not met. This code is assigned APC 5025 with OPPS Addendum A rate of $520.85, multiplied by 60% for an unadjusted labor amount of $312.51, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $257.01. The non-labor portion is 40% of the APC rate, or $208.34. The sum of the labor and non-labor portions is the Medicare facility specific amount of $465.35. This is multiplied by 200% for a MAR of $930.70.
- Procedure codes Q9967, 90715, and J7040 have status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code G0390 represents trauma team activation. Per Medicare payment policy, this code is paid only when billed in conjunction with a critical care service. When trauma response is billed without critical care services, payment for trauma activation is bundled with the payment for other services performed that day. As no critical care service code is present, reimbursement for this service is bundled; separate payment is not recommended.
- Procedure codes 70450, 72125, 71260 and 74177 have status indicator Q3, for packaged codes paid as a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. If a "without contrast" CT and a "with contrast" CT are billed together, APC 8006 is assigned instead of APC 8005. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast. The OPPS Addendum A rate is $500.85, multiplied by 60% for an unadjusted labor amount of $300.51, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $247.14. The non-labor portion is 40% of the APC rate, or $200.34. The sum of the labor and non-labor portions is the Medicare facility specific amount of $447.48. This is multiplied by 200% for a MAR of $894.96.

The total recommended reimbursement for the disputed services is $2,278.12. The insurance carrier paid $2,278.12. The balance due is $0.00. 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 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 not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 10, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.