



# 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**

Atlantic Specialty Ins Co

**MFDR Tracking Number**

M4-19-4620-01

**Carrier's Austin Representative**

Box Number 29

**MFDR Date Received**

June 24, 2019

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** Review of the submitted documentation found no position statement submitted.

**Amount in Dispute:** \$1,633.58

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "...we have escalated the bills in question for bill review audit and payment."

**Response Submitted by:** Gallagher Bassett

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2018	Outpatient Hospital Services	\$1,633.58	\$1,581.64

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service

## Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

## Findings

1. The requestor is seeking reimbursement in the amount of \$1,633.58 for outpatient hospital services rendered on October 14, 2018. The insurance carrier denied the disputed services based on provider not eligible based on existing network.

The explanation of benefits indicates, "Coventry Integrated Network" which is listed as a certified network on the Division's webpage, the carrier did not provide convincing evidence that the injured employee is enrolled in this network, nor did the carrier provide documentation to support that the requestor was not eligible at the time of service.

The Division concludes that the carrier failed to support its reasons for reduction of payment. Therefore, the service in dispute will be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical bill found no separate request for implants. The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 81001 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 73560 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure code 71045 has status indicator Q3, for packaged codes paid through a composite APC (if OPPS criteria are met). As packaging criteria are not met, this line is separately paid. This line is assigned status indicator S, for procedures not subject to reduction. This code is assigned APC 5521. The OPPS Addendum A rate is \$62.12, 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 \$55.50. The Medicare facility specific amount of \$55.50 is multiplied by 200% for a MAR of \$111.00.
- Procedure code 99285 has status indicator J2 when comprehensive packaging criteria of 8 or more hours observation billed. Review of the submitted medical bill finds criteria is not met. This code is assigned status indicator V. The OPPS Addendum A rate is \$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 \$465.35. The Medicare facility specific amount of \$465.35 is multiplied by 200% for a MAR of \$930.70.

- Procedure code 96374 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 \$170.73. The Medicare facility specific amount of \$170.73 is multiplied by 200% for a MAR of \$341.46.
  - Procedure code 96375 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is \$37.03, multiplied by 60% for an unadjusted labor amount of \$22.22, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of \$18.27. The non-labor portion is 40% of the APC rate, or \$14.81. The sum of the labor and non-labor portions is \$33.08 multiplied by 2 units is \$66.16. The Medicare facility specific amount of \$66.16 is multiplied by 200% for a MAR of \$132.32.
2. The total recommended reimbursement for the disputed services is \$1,581.64. The insurance carrier paid \$0.00. The amount due is \$1,581.64. This amount is recommended.

**Conclusion**

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 \$1,581.64.

***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 \$1,581.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	August 29, 2019 Date
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***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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

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 instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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.**