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
Doctor's Hospital at Renaissance

Respondent Name
Texas Municipal League Intergovernmental Risk Pool

MFDR Tracking Number
M4-19-4737-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 29727, allowed amount of $5,092.24, multiplied at 130%..."

Amount in Dispute: $3,277.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has already been reimbursed. The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16 – 18, 2019	Outpatient Hospital Services	$3,277.03	$0.00

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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation Jurisdictional fee schedule adjustment
   - 370 – This Hospital Outpatient allowance was calculated according to the APC rate, plus a markup
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - A45 – Reductions have been made per Alliance Contractual agreement

Issues

1. Is the insurance carrier's reason for reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $3,277.03 for outpatient hospital services rendered on April 16 – 18, 2019. The insurance carrier used the A45 modifier stating a contractual agreement was in place. Review of the submitted documentation found the "Alliance" contract was not found on the Division's Workers' Compensation Health Care Network or was convincing evidence found to support a contractual agreement existed. This reduction code will not be considered in this review. The services in dispute will be reviewed per applicable fee guideline.
2. The applicable fee guideline is found in 28 Texas Administrative Code §134.403 (f) which 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 insufficient evidence to support the health care provider made a separate request for implants. The maximum allowable reimbursement is calculated as follows:

- Procedure code 29827 has status indicator J1 and is assigned APC 5114. The OPPS Addendum A rate is $5,699.59, multiplied by 60% for an unadjusted labor amount of $3,419.75, in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $2,812.40. The non-labor portion is 40% of the APC rate, or $2,279.84. The sum of the labor and non-labor portions is $5,092.24. The Medicare facility specific amount of $5,092.24 is multiplied by 200% for a MAR of $10,184.48.
- Procedure code 29807 has a status indicator of J1 but, per the Medicare Claims Processing Manual, Chapter 4, Section 10.2.3 - Comprehensive APCs,

  Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

  Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

  • *lower ranked comprehensive procedure codes (status indicator J1)*

  The ranking of Procedure code 29807 is lower than the ranking of Procedure code 29827. This code is not separately payable.
- Procedure code 93005 is packaged with J1 Comprehensive APC
- Procedure code 96375 is packaged with J1 Comprehensive APC
- Procedure code 96374 is packaged with J1 Comprehensive APC

3. The total recommended reimbursement for the disputed services is $10,184.48. The insurance carrier paid $11,262.64. Additional payment is not recommended.

Conclusion

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

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

		July 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, 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.