



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

PHYSICIANS SURGICAL HOSPITAL

Respondent Name

NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number

M4-19-5380-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 30, 2019

Response Submitted By

Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"Carrier issued reimbursement in the amount of \$9626.77 based on the applicable fee guidelines."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 9, 2019	Outpatient Hospital Services	\$464.75	\$464.75

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 (DWC).

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.
- Texas Insurance Code Chapter 1305 sets out requirements for workers' compensation health care networks.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
 - 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.
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
 - 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.
 - 877 – REIMBURSEMENT IS BASED ON THE CONTRACTED AMOUNT.
 - 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

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:

- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
- 877 – REIMBURSEMENT IS BASED ON THE CONTRACTED AMOUNT.

Based on information maintained by DWC, the carrier has not previously reported or provided notice to DWC that the injured employee is enrolled in a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305. Review of the submitted documentation finds no information to support the medical provider is contracted with the insurance carrier or with an HCN to which the insurance carrier has access. No evidence was presented to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

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

2. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors 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 hospital facility services. Separate reimbursement for implants was not requested.

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 29827 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is \$5,699.59. This is multiplied by 60% for an unadjusted labor amount of \$3,419.75, and in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of \$2,788.46. The non-labor portion is 40% of the APC rate, or \$2,279.84. The cost of services does not exceed the thresholds for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of \$5,068.30. This is multiplied by 200% for a MAR of \$10,136.60.
- 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.

The total recommended reimbursement for the disputed services is \$10,136.60. The insurance carrier paid \$9,629.77. The requestor is seeking additional reimbursement of \$464.75. This amount is recommended.

Conclusion

For the reasons above, the requestor has established additional payment is due. As a result, the amount ordered is \$464.75.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor \$464.75, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

September 25, 2019
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 TAC §133.307. The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within **twenty** days of your receipt of this decision. You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d). Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.