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

NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number

M4-20-0408-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 16, 2019

Response Submitted By

Travelers

REQUESTOR'S POSITION SUMMARY

"Reimbursement should be $6,424.66. Payment received was only $4,687.60, thus, according to these calculations; there is a pending payment in the amount of $1,737.06."

RESPONDENT'S POSITION SUMMARY

"Reimbursement was issued in accordance with the Maximum Allowable Reimbursement as determined under the Division's fee schedule."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 2, 2019	Outpatient Hospital Services	$1,737.86	$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 (DWC) in Title 28, Part 2 of the Texas Administrative Code.

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:
   - 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.
   - 96 – NON-COVERED CHARGE(S).
   - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
   - 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.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - 797 – SERVICE NOT PAID UNDER MEDICARE OPPS.
   - 906 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING INITIATIVE/OUTPATIENT CODE EDITOR), COMPONENT CODE OF COMPREHENSIVE MEDICINE, EVALUATION AND MANAGEMENT SERVICES PROCEDURE (90000-99999) HAS BEEN DISALLOWED.

- 8751 - After review, the billed service is not reimbursable based on AMA guidelines. The billed service is considered inclusive into the surgical service billed.
- 292 – THIS PROCEDURE CODE IS ONLY REIMBURSED WHEN BILLED WITH THE APPROPRIATE INITIAL BASE CODE.
- 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES
- Z003 – Please advise if you have a specific question regarding this claim.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- Z001 – For explanation of a non-payment by the adjuster, please contact the adjuster on file.

Findings

This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §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 28 TAC §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for these hospital services. Medicare assigns Ambulatory Payment Classifications (APC) to OPPS services based on billed procedure codes and records. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes rate updates at www.cms.gov. Reimbursement is calculated as follows:

- Procedure codes 26785 and 26735 have status indicator J1, for procedures paid at a comprehensive rate. All services on the bill are packaged with the primary "J1" procedure, code 26735. Both codes are assigned to APC 5113, which has an OPPS Addendum A rate of $2,623.34. This is multiplied by 60% for an unadjusted labor amount of $1,574.00, and in turn multiplied by facility wage index 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 sum of the labor and non-labor portions is the Medicare facility specific 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.

The total recommended payment for the disputed services is $4,687.60. The insurance carrier paid $4,687.60. The amount due is $0.00. No additional payment is recommended.

Conclusion

For the reasons above, the requestor has not established additional payment is due. The amount ordered is $0.00.

ORDER

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

Authorized Signature

	Grayson Richardson	November 8 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 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.