

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

USMD HOSPITAL
ARLINGTON

Respondent Name

NEW ALBERTSONS INC

MFDR Tracking Number

M4-21-2429-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 26, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 29, 2021	Hospital Outpatient Service	\$1,927.17	\$1,927.17
Total		\$1,927.17	\$1,927.17

Requestor's Position

"Please reprocess this bill per the Rule at 200% of the Medicare OPPS for APC 5431 which is \$1,710.07. ($\$1,710.07 \times 200\% = \$3,420.14$). The Rule is per Total Billed charges, not line items."

Amount in Dispute: \$1,927.17

Respondent's Position

"The Austin carrier representative for New Albertson Inc is Flahive, Ogden & Latson. Flahive, Ogden & Latson was notified of this medical fee dispute on August 31, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1)."

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- CA193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- APP – No additional allowance is recommended regarding the appeal/second review
- TXM – Reduced to fair and reasonable
- ANS – Standard reduction

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code 87635, billed April 28, 2021, has status indicator A, for services paid by fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the code on the date provided. Per DWC Professional Fee Guideline, Rule §134.203(e)(1), the facility fee is based on Medicare's Clinical Laboratory fee for this code of \$0.00. 125% of this amount is \$0.00.
- Procedure code 64635 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 5431. The OPPS Addendum A rate is \$1,754.39. This is multiplied by 60% for an unadjusted labor amount of \$1,052.63, in turn multiplied by facility wage index 0.9707 for an adjusted labor amount of \$1,021.79. The non-labor portion is 40% of the APC rate, or \$701.76. The sum of the labor and non-labor portions is \$1,723.55. The provider billed this code with modifier 50. Bilateral procedures are paid at the rate for two units. The APC amount is \$3,447.10. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is \$3,447.10. This is multiplied by 200% for a MAR of \$6,894.20.
- Procedure code 64636 has 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.
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- Procedure code 99152 has 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 99153 has 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 J1030 has 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 J2250 has 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 J2270 has 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 J2550 has 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.
4. The total recommended reimbursement for the disputed services is \$6,894.20. The insurance carrier paid \$1,492.97. The requestor is seeking additional reimbursement of \$1,927.17. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has established that additional reimbursement of \$1,927.17 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that New Albertsons Inc must remit to USMD HOSPITAL ARLINGTON \$1,927.17 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature



Signature



Medical Fee Dispute Resolution Officer

October 19, 2021

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.