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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRISTUS ST ELIZABETH HOSPITAL
C/O HOLLOWAY & GUMBERT
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3926

Respondent Name
INSURANCE COMPANY OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-7274-01

MFDR Date Received
March 26, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill should have been paid in accordance with 28 T.A.C. § 134.403 . . . The Carrier has split this bill numerous times and failed clearly state the method or reasoning for its reductions. . . . it is the position of the Provider that all charges relating to the care of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case."

Amount in Dispute: $11,257.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our reimbursement was partly calculated based upon a managed care plan/capitation agreement."

Response Submitted by: AIU Holdings, Inc., 4100 Alpha Road, Suite 700, Dallas, Texas 75244

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2008 to September 9, 2008	Outpatient Hospital Services	$11,257.72	$9,174.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.20 sets out medical bill submission requirements for health care providers.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
5. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

6. Texas Labor Code §408.027 sets out provisions relating to payment of health care providers.
7. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – Duplicate claim/service.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 96 – Non-covered charge(s).
   - 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
   - 42 – Charges exceed our fee schedule or maximum allowable amount.
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - D19 – Claim/Service lacks Physician/Operative or other supporting documentation.
   - 29 – The time limit for filing has expired.

Issues

1. Did the requestor timely file the dispute with the Division?
2. Did the requestor timely file the bill with the insurance carrier?
3. Are the disputed services subject to a contractual agreement between the parties to this dispute?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The request for dispute resolution of services rendered from dates of service March 25, 2008 to September 9, 2008 was received by the Division on March 26, 2009. This date is later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution with respect to disputed date of service March 25, 2008. This date will not be considered in this review. However the remaining dates of service, rendered subsequent to March 25, 2008, were timely filed in accordance with the requirements of §133.307(c); therefore, those services will be considered in this review.

2. The insurance carrier denied procedure code 20005, service date April 21, 2008, with reason code 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b), effective May 2, 2006, 31 *Texas Register* 3544 requires that a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." Review of the submitted documentation finds that procedure code 20005 was not submitted with the original bill submission, but was submitted as part of a corrected claim with creation date October 28, 2008 indicated on the medical bill. This date is later than the 95th day after the date the services were provided. No documentation was submitted to support timely filing with the insurance carrier. The insurance carrier's reason code is supported. The Division concludes that the requestor has not met the requirements of §133.20(b) with respect to procedure code 20005, and has therefore forfeited the right to reimbursement. Payment cannot be recommended for this service.

3. The insurance carrier reduced or denied disputed services with reason codes 45 – "Charges exceed your contracted/legislated fee arrangement"; 24 – "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan."; and 42 – "Charges exceed our fee schedule or maximum allowable amount." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a capitation agreement, managed care plan or contractual fee arrangement between the parties to this dispute. Nevertheless, on October 26, 2010, the Division requested additional information from the respondent pursuant to 28 Texas Administrative Code §133.307(e)(1), which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division

may base its decision on the information available." The Division requested the respondent to provide a copy of the referenced contract(s) to support that the disputed services were subject to a contractual fee arrangement. In addition, the Division requested documentation to support that the health care provider had been notified in accordance with 28 Texas Administrative Code §133.4, effective July 27, 2008, 33 *Texas Register* 5701, applicable to services rendered between August 1, 2008 and December 31, 2010, that the insurance carrier, The Insurance Company of the State of Pennsylvania, had been granted access to the alleged contractual fee arrangement between the alleged informal/voluntary network and the health care provider. Review of the submitted information found insufficient evidence to support a contract between the parties to this dispute. The respondent did not submit a complete copy of the requested contract, but rather only a copy of an amendment to the contract and select fee schedule information. The amendment was signed in 2005. The fee schedule information was dated in 2007 but was not signed by either party. No documentation was found to support that the insurance carrier, The Insurance Company of the State of Pennsylvania, was a contracted payor with the alleged network, nor was any documentation found to support that the insurance carrier had been granted access to the alleged contractual fee arrangement between the third party network and the health care provider. Despite a letter from the network stating that the health care provider "has been made aware of their participation status" with the alleged network, no documentation was submitted to support that the health care provider had been given notice that the insurance carrier, The Insurance Company of the State of Pennsylvania, was an authorized payor under the terms of the alleged contract. Additionally, no documentation was submitted to support that the health care provider had been given written notice, in accordance with the requirements of §133.4, that the insurance carrier had been granted access to the alleged contractual fee arrangement between the informal/voluntary network and the health care provider. §133.4(e) requires that "The informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d) of this section, the method of delivery, to whom the notice was delivered, and the date of delivery." It further provides that "Failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action and in a medical fee dispute that the health care provider did not receive the notification." In such case, per §133.4(g) "The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if: (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115." As a consequence, per §133.4(h), "If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement)." After thoroughly considering the submitted documentation, the Division concludes that the respondent has failed to support that the insurance carrier, The Insurance Company of the State of Pennsylvania, was entitled to access a contractual fee arrangement between the health care provider and the third party network. Moreover, the respondent has failed to establish that the disputed services are subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011. Further, for the dates of service to which §133.4 is applicable, the Division finds that the insurance carrier has failed to meet the requirements of §133.4 and is thus not entitled to pay the health care provider at a contracted rate. The Division fee guidelines apply, and the disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

4. This dispute relates to facility services performed in an outpatient hospital setting 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. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

5. 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 A6253, service date April 23, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $6.34. This amount multiplied by 3 units is $19.02. 125% of this amount is $23.78
- Procedure code A6253, service date April 24, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $6.34. This amount multiplied by 2 units is $12.68. 125% of this amount is $15.85
- Procedure code A6253, service date April 22, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $6.34. This amount multiplied by 5 units is $31.70. 125% of this amount is $39.63. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $19.36. The lesser amount is $19.36. The insurance carrier reduced payment to $13.55 based on reason code 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service." Review of the submitted information finds that the requestor did not submit medical documentation to support the service as billed, therefore the insurance carrier's reduction reason is supported; no additional reimbursement can be recommended for this service.
- Procedure code A6213, service date April 15, 2008, represents an item or service for which payment is bundled into payment for other services billed on the same date of service. Separate payment is not recommended.
- Procedure code A6253, service date April 30, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $6.34. 125% of this amount is $7.93
- Procedure code A6455, service date April 30, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $1.39. 125% of this amount is $1.74
- Procedure code A6223, service date April 30, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $2.42. This amount multiplied by 2 units is $4.84. 125% of this amount is $6.05. The insurance carrier reduced payment to $5.42 based on reason code 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service." Review of the submitted information finds that the requestor did not submit medical documentation to support the service as billed, therefore the insurance carrier's reduction reason is supported; no additional reimbursement can be recommended for this service.
- Procedure code A6223, service date April 24, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $2.42.

125% of this amount is $3.03. The insurance carrier reduced payment to $2.71 based on reason code 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service." Review of the submitted information finds that the requestor did not submit medical documentation to support the service as billed, therefore the insurance carrier's reduction reason is supported; no additional reimbursement can be recommended for this service.

- Procedure code 87070 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.03. 125% of this amount is $15.04
- Procedure code 87205 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.96. 125% of this amount is $7.45
- Procedure code 88304 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 343, which, per OPPS Addendum A, has a payment rate of $32.75. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.65. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $16.93. The non-labor related portion is 40% of the APC rate or $13.10. The sum of the labor and non-labor related amounts is $30.03 multiplied by 3 units is $90.09. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $90.09. This amount multiplied by 200% yields a MAR of $180.18. The insurance carrier reduced payment for this service based on reason code 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service." Review of the submitted pathology and specimen reports finds that the medical documentation does support this surgical pathology service as billed. The insurance carrier's reduction reason is not supported; therefore, the fee guideline MAR of $180.18 is recommended.
- Procedure code 20005 was denied by the insurance carrier with reason code 29 – "The time limit for filing has expired." As stated above, the requestor failed to support that the medical bill was timely submitted to the insurance carrier for consideration of payment. The insurance carrier's denial reason is supported. Reimbursement cannot be recommended for this service.
- Procedure code C1300, service date April 23, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date April 24, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date April 25, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar

threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.

- Procedure code C1300, service date April 28, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date April 29, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date April 30, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code 99213, service date April 15, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 605, which, per OPPS Addendum A, has a payment rate of $63.46. This amount multiplied by 60% yields an unadjusted labor-related amount of $38.08. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $32.81. The non-labor related portion is 40% of the APC rate or $25.38. The sum of the labor and non-labor related amounts is $58.19. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $58.19. This amount multiplied by 200% yields a MAR of $116.38.
- Procedure code 99213, service date April 22, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 605, which, per OPPS Addendum A, has a payment rate of $63.46. This amount multiplied by 60% yields an unadjusted labor-related amount of $38.08. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $32.81. The non-labor related portion is 40% of the APC rate or $25.38. The sum of the labor and non-labor related amounts is $58.19. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $58.19. This amount multiplied by 200% yields a MAR of $116.38.
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40% of the APC rate or $25.38. The sum of the labor and non-labor related amounts is $58.19. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $58.19. This amount multiplied by 200% yields a MAR of $116.38.

- Procedure code 99213, service date April 25, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 605, which, per OPPS Addendum A, has a payment rate of $63.46. This amount multiplied by 60% yields an unadjusted labor-related amount of $38.08. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $32.81. The non-labor related portion is 40% of the APC rate or $25.38. The sum of the labor and non-labor related amounts is $58.19. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $58.19. This amount multiplied by 200% yields a MAR of $116.38.
- Procedure code 99213, service date April 28, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 605, which, per OPPS Addendum A, has a payment rate of $63.46. This amount multiplied by 60% yields an unadjusted labor-related amount of $38.08. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $32.81. The non-labor related portion is 40% of the APC rate or $25.38. The sum of the labor and non-labor related amounts is $58.19. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $58.19. This amount multiplied by 200% yields a MAR of $116.38.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2550 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93923, service date April 15, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 96, which, per OPPS Addendum A, has a payment rate of $93.56. This amount multiplied by 60% yields an unadjusted labor-related amount of $56.14. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $48.37. The non-labor related portion is 40% of the APC rate or $37.42. The sum of the labor and non-labor related amounts is $85.79. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $85.79. This amount multiplied by 200% yields a MAR of $171.58.
- Procedure code 87070, service date May 13, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.03. 125% of this amount is $15.04
- Procedure code 87205, service date May 13, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.96. 125% of this amount is $7.45
- Procedure code 99183, service date May 1, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99183, service date May 2, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99183, service date May 16, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99183, service date May 19, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.

- Procedure code 99183, service date May 20, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99183, service date May 21, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99183, service date May 22, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99183, service date May 23, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99183, service date May 28, 2008, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 97597, service date May 13, 2008, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 15, which, per OPPS Addendum A, has a payment rate of $92.96. This amount multiplied by 60% yields an unadjusted labor-related amount of $55.78. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $48.06. The non-labor related portion is 40% of the APC rate or $37.18. The sum of the labor and non-labor related amounts is $85.24. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $85.24. This amount multiplied by 200% yields a MAR of $170.48. The insurance carrier reduced payment to $121.77 based on reason codes D19 – “Claim/Service lacks Physician/Operative or other supporting documentation” and 150 – “Payment adjusted because the payer deems the information submitted does not support this level of service.” Review of the submitted information finds that the requestor did not submit medical documentation to support the service as billed, therefore the insurance carrier’s reduction reason is supported; no additional reimbursement can be recommended for this service.
- Procedure code 99214, service date May 21, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 606, which, per OPPS Addendum A, has a payment rate of $84.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $50.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $43.55. The non-labor related portion is 40% of the APC rate or $33.70. The sum of the labor and non-labor related amounts is $77.25. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $77.25. This amount multiplied by 200% yields a MAR of $154.50.
- Procedure code 99213, service date May 5, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 605, which, per OPPS Addendum A, has a payment rate of $63.46. This amount multiplied by 60% yields an unadjusted labor-related amount of $38.08. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $32.81. The non-labor related portion is 40% of the APC rate or $25.38. The sum of the labor and non-labor related amounts is $58.19. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $58.19. This amount multiplied by 200% yields a MAR of $116.38.
- Procedure code 99213, service date May 28, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 605, which, per OPPS Addendum A, has a payment rate of $63.46. This amount multiplied by 60% yields an unadjusted labor-related amount of $38.08. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $32.81. The non-labor related portion is 40% of the APC rate or $25.38. The sum of the labor and non-labor related amounts is $58.19. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $58.19. This amount multiplied by 200% yields a MAR of $116.38.
- Procedure code A6199, service date June 20, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $5.29. 125% of this amount is $6.61

- Procedure code A6196, service date June 13, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $7.35. 125% of this amount is $9.19
- Procedure code 87070, service date June 20, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.03. 125% of this amount is $15.04
- Procedure code 87205, service date June 20, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.96. 125% of this amount is $7.45
- Procedure code 10061, service date June 20, 2008, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 6, which, per OPPS Addendum A, has a payment rate of $89.59. This amount multiplied by 60% yields an unadjusted labor-related amount of $53.75. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $46.31. The non-labor related portion is 40% of the APC rate or $35.84. The sum of the labor and non-labor related amounts is $82.15. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $41.08. This amount multiplied by 200% yields a MAR of $82.16.
- Procedure code C1300, service date June 2, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 3, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 4, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 5, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment.

These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.

- Procedure code C1300, service date June 6, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 9, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 10, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 11, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 12, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 13, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.

- Procedure code C1300, service date June 16, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 17, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 18, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 19, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 20, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 23, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 24, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar

threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.

- Procedure code C1300, service date June 25, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 26, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 27, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date June 30, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code 99214, service date June 13, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 606, which, per OPPS Addendum A, has a payment rate of $84.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $50.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $43.55. The non-labor related portion is 40% of the APC rate or $33.70. The sum of the labor and non-labor related amounts is $77.25. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $77.25. This amount multiplied by 200% yields a MAR of $154.50.
- Procedure code Q0179, service date June 18, 2008, has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 769, which, per OPPS Addendum A, has a payment rate of $18.37. This amount multiplied by 60% yields an unadjusted labor-related amount of $11.02. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $9.49. The non-labor related portion is 40% of the APC rate or $7.35. The sum of the labor and non-labor related amounts is $16.84. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is $16.84. This amount multiplied by 200% yields a MAR of $33.68.
- Procedure code A4338, service date July 8, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was

provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $12.26. 125% of this amount is $15.33

- Procedure code A4357, service date July 8, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $8.25. 125% of this amount is $10.31
- Procedure code C1300, service date July 1, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date July 2, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date July 3, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code C1300, service date July 7, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 659, which, per OPPS Addendum A, has a payment rate of $99.23. This amount multiplied by 60% yields an unadjusted labor-related amount of $59.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $51.30. The non-labor related portion is 40% of the APC rate or $39.69. The sum of the labor and non-labor related amounts is $90.99 multiplied by 4 units is $363.96. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $363.96. This amount multiplied by 200% yields a MAR of $727.92.
- Procedure code 99214, service date July 8, 2008, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 606, which, per OPPS Addendum A, has a payment rate of $84.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $50.54. This amount multiplied by the annual wage index for this facility of 0.8616 yields an adjusted labor-related amount of $43.55. The non-labor related portion is 40% of the APC rate or $33.70. The sum of the labor and non-labor related amounts is $77.25. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $77.25. This amount multiplied by 200% yields a MAR of $154.50.

6. The total recommended reimbursement for the services in dispute is $24,729.32. The insurance carrier has presented documentation to support previous payments in the amount of $4,038.74, $8,809.31, $541.62, $907.97, $202.62, $177.28, $705.13, and $172.65 toward the services in dispute, for a total amount paid of $15,555.32, which leaves a remaining amount due to the requestor of $9,174.00. 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 $9,174.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,174.00, 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	January 16, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.