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
DOCTORS HOSPITAL OF LAREDO

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-09-8815-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 28, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medicare would have allowed this facility $594.28 the MAR at 200%. Based on their payment, a supplemental payment of $347.40 is due."

Amount in Dispute: $347.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 99284 Inclusive 29530 Rule 134.403(D). PPO discount also taken verified with First Health. . . . Contacted Aetna pd correctly — rule is 70% billed charge or 100% fee which is less."

Response Submitted by: Zurich American Insurance Company, 300 S. State St., Syracuse, New York 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2008	Outpatient Hospital Services	$347.40	$347.40

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY. REDUCED TO FAIR AND REASONABLE.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - PRICED ACCORDING TO THE STATE APC FEE SCHEDULE RATE.
   - MAR AMOUNT IS GREATER THEN THE CHARGED AS PER TEXAS HOSPITAL GUIDELINES.
   - W2 – WORKERS COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. CARRIER NOT LIABLE FOR SERVICE/TREATMENT. PAYMENT INCLUDED IN APC RATE PER THE TX HOSPITAL MEDICARE METHODOLOGY PER RULE 134.403(D)

- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE FOCUS/AETNA WORKERS COMP ACCESS LLC CONTRACT. FOR Q4UESTIONS REGARDING NETWORK REDUCTIONS, PLEASE CALL 1-800-243-2336.
- W4 – NO ADDL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION. REIMBURSEMENT FOR RECONSIDERED INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO PPO CONTRACT.
- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SVC/PX THAT HAS ALREADY ADJUDICATED. PAYMENT INCLUDED IN APC RATE PER THE TX HOSPITAL MEDICARE METHODOLOGY PER FRULE 134.403(D).

Issues

1. Are there unresolved issues related to compensability or liability for the disputed services?
2. Are the disputed services subject to a contractual fee arrangement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code W2 – "WORKERS COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. CARRIER NOT LIABLE FOR SERVICE/TREATMENT. PAYMENT INCLUDED IN APC RATE PER THE TX HOSPITAL MEDICARE METHODOLOGY PER RULE 134.403(D)" Upon reconsideration, the insurance carrier did not maintain this denial reason. The Division therefore concludes that there are no unresolved issues related to compensability or liability for the disputed services.
2. The insurance carrier reduced payment for disputed services with reason code 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE FOCUS/AETNA WORKERS COMP ACCESS LLC CONTRACT. FOR Q4UESTIONS REGARDING NETWORK REDUCTIONS, PLEASE CALL 1-800-243-2336." No documentation was found to support a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011 between the parties to this dispute. Nevertheless, on September 22, 2010, the Division requested additional information from the respondent to support any asserted contractual agreement between the parties, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 *Texas Register* 10314, 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." Review of the submitted information finds no documentation of a contract between the insurance carrier, Zurich American Insurance Company, and the health care provider. No documentation was found to support that the insurance carrier, Zurich American Insurance Company, was contracted with the alleged insurance network through which it sought access to a contracted fee schedule between the health care provider and a third party. No documentation was found to support that the insurance carrier, Zurich American Insurance Company, had been granted access to the health care provider's contracted fee schedule with the alleged network. The insurance carrier has not supported this payment reduction reason. The disputed services will therefore be considered in accordance with applicable Division rules and fee guidelines.
3. 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.
4. 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 73562 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 260, which, per OPPS Addendum A, has a payment rate of $44.29. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.57. This amount multiplied by the annual wage index for this facility of 0.8501 yields an adjusted labor-related amount of $22.59. The non-labor related portion is 40% of the APC rate or $17.72. The sum of the labor and non-labor related amounts is $40.31. 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 $40.31. This amount multiplied by 200% yields a MAR of $80.62.
- Procedure code 29530 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 58, which, per OPPS Addendum A, has a payment rate of $69.62. This amount multiplied by 60% yields an unadjusted labor-related amount of $41.77. This amount multiplied by the annual wage index for this facility of 0.8501 yields an adjusted labor-related amount of $35.51. The non-labor related portion is 40% of the APC rate or $27.85. The sum of the labor and non-labor related amounts is $63.36. 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 $63.36. This amount multiplied by 200% yields a MAR of $126.72.
- Procedure code 99284 has a status indicator of Q, which denotes conditionally packaged services that may be separately payable only if OPPS criteria are met. However, review of the submitted information finds that the criteria for separate reimbursement have been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 615, which, per OPPS Addendum A, has a payment rate of $212.59. This amount multiplied by 60% yields an unadjusted labor-related amount of $127.55. This amount multiplied by the annual wage index for this facility of 0.8501 yields an adjusted labor-related amount of $108.43. The non-labor related portion is 40% of the APC rate or $85.04. The sum of the labor and non-labor related amounts is $193.47. 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 $193.47. This amount multiplied by 200% yields a MAR of $386.94.

5. The total allowable reimbursement for the services in dispute is $594.28. This amount less the amount previously paid by the insurance carrier of $246.88 leaves an amount due to the requestor of $347.40. 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 $347.40.

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 $347.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 27, 2014
Signature	Medical Fee Dispute Resolution Officer	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.