TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FORT DUNCAN MEDICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-09-9295-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 8, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medicare would have allowed this facility $2,383.66 for the MAR at 200%. Based on their payment, a supplemental payment of $256.55 is due."

Amount in Dispute: $256.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual correctly paid the requestor by the terms of the PPO contract. And Texas Mutual correctly paid by the terms of Rule 134.403."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2008	Outpatient Hospital Services	$256.55	$0.00

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 §133.307 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.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY).
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 494 – HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED TO MEDICARE'S METHODOLOGY PLUS A MARKUP PER THE TEXAS OMFS.
   - 618 – THE VALUE OF THIS PROCEDURE IS IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS/AETNA WORKERS COMP ACCESS LLC. FOR PROVIDER SUPPORT 1-800-243-2336.
   - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
   - 420 – SUPPLEMENTAL PAYMENT.
   - 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION.
   - 18 – DUPLICATE CLAIM/SERVICE.
   - 878 – DUPLICATE APPEAL. REQUEST MEDICAL DISPUTE RESOLUTION THROUGH DWC FOR CONTINUED DISAGREEMENT OF ORIGINAL APPEAL DECISION.

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. The insurance carrier reduced or denied disputed services with reason code 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY)." The respondent asserts, "Texas Mutual correctly paid the requestor by the terms of the PPO contract. " Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contracted fee arrangement between the parties to this dispute. The respondent did not submit documentation to support that it met the requirements of Division Rule at 28 Texas Administrative Code §133.4 regarding written notification to health care providers of contractual agreements for informal and voluntary networks.
   - The submitted contract is between the health care provider and an informal or voluntary network.
   - No documentation was provided to support that the insurance carrier is a party to the alleged contract.
   - No documentation was found to support the insurance carrier had been granted access to the health care provider's fee arrangement with the alleged network during the period the services were rendered.
   - No documentation was presented to support that the health care provider had been given notice, in the time and manner required by §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time the disputed services were rendered.

   The Division concludes, pursuant to §133.4(g), that the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute involves 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.

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 80048 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 $11.83. 125% of this amount is $14.79
   - Procedure code 73030 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, 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 0.8124 yields an adjusted labor-related amount of $21.59. 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 $39.31. 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 $39.31. This amount multiplied by 200% yields a MAR of $78.62.
   - Procedure code 73060 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, 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 0.8124 yields an adjusted labor-related amount of $21.59. 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 $39.31. 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 $39.31. This amount multiplied by 200% yields a MAR of $78.62.
   - Procedure code 73070 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, 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 0.8124 yields an adjusted labor-related amount of $21.59. 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 $39.31. 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 $39.31. This amount multiplied by 200% yields a MAR of $78.62.
   - Procedure code 71260 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 0283, which, per OPPS Addendum A, has a payment rate of $277.48. This amount multiplied by 60% yields an unadjusted labor-related amount of $166.49. This amount multiplied by the annual wage index for this facility of 0.8124 yields an adjusted labor-related amount of $135.26. The non-labor related portion is 40% of the APC rate or $110.99. The sum of the labor and non-labor related amounts is $246.25. 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 $246.25. This amount multiplied by 200% yields a MAR of $492.50.

- Procedure code 72193 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 0283, which, per OPPS Addendum A, has a payment rate of $277.48. This amount multiplied by 60% yields an unadjusted labor-related amount of $166.49. This amount multiplied by the annual wage index for this facility of 0.8124 yields an adjusted labor-related amount of $135.26. The non-labor related portion is 40% of the APC rate or $110.99. The sum of the labor and non-labor related amounts is $246.25. 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 $246.25. This amount multiplied by 200% yields a MAR of $492.50.
- Procedure code 74160 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 0283, which, per OPPS Addendum A, has a payment rate of $277.48. This amount multiplied by 60% yields an unadjusted labor-related amount of $166.49. This amount multiplied by the annual wage index for this facility of 0.8124 yields an adjusted labor-related amount of $135.26. The non-labor related portion is 40% of the APC rate or $110.99. The sum of the labor and non-labor related amounts is $246.25. 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 $246.25. This amount multiplied by 200% yields a MAR of $492.50.
- Per Medicare policy, procedure code 90772 may not be reported with procedure codes 71260, 72193 and 74160 billed on the same claim. Payment for this service is included in the reimbursement for other services performed. Separate payment is not recommended.
- Procedure code 99284 indicates Emergency Evaluation and Management classified under APC 0615, 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 0.8124 yields an adjusted labor-related amount of $103.62. 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 $188.66. 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 $188.66. This amount multiplied by 200% yields a MAR of $377.32.
- 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 Q9967 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 90714 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.

4. The total allowable reimbursement for the services in dispute is $2,105.47. This amount less the amount previously paid by the insurance carrier of $2,160.79 leaves an amount due to the requestor of $0.00. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	December 4, 2015
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 MFDR 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 this *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.