



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Doctors Hospital at Renaissance

**Respondent Name**

Trumbull Insurance Co

**MFDR Tracking Number**

M4-17-3094-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

June 20, 2017

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

**Amount in Dispute:** \$573.48

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "As reflected in the EOB's Trumbull properly reimbursed Doctors Hospital at Renaissance in accordance with the Texas Workers' Compensation and Division Rules."

**Response Submitted by:** Burns Anderson Jury & Brenner, L.L.P.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2016	25609, 94770, 96374	\$573.48	\$22.06

#### FINDINGS AND DECISION

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

#### **Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - W3 – Additional payment made on appeal/reconsideration
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
  - OA – The amount adjusted is due to bundling or unbundling of services

## Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The requestor is seeking additional reimbursement in the amount of \$573.48 for services rendered at an outpatient facility on October 25, 2016.

The insurance carrier reduced codes 25609 – “Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments” and 94770 – “Carbon dioxide, expired gas determination by infrared analyzer,” with adjustment reason code OA – “The amount adjusted is due to bundling or unbundling of services.” Review of the submitted explanation of benefits could find no indication that code 96374 was considered by the carrier.

As the codes in dispute are outpatient services the reimbursement guidelines are found in 28 Texas Administrative Code §134.403 which states in the pertinent parts,

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

And,

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

The Medicare policies and applicable fee guidelines are detailed in the following paragraph.

2. The Medicare payment policies are described as;
  - **How Payment Rates Are Set**, found at [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf)
    - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
  - **Medicare Claims Processing Manual, Chapter 4, Section 10.1.1 - Payment Status Indicators**

*An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.*

*The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.*
  - **Medicare Claims Processing Manual, Chapter 4, Section 10.2 - APC Payment Groups**

*Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount*

*calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).*

The services in dispute have the payment indicators indicate below;

- Procedure code 25609 has status indicator J1, denoting packaged services paid at a comprehensive APC rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This is assigned APC 5123. The OPSS Addendum A rate is \$4,969.26. This is multiplied by 60% for an unadjusted labor-related amount of \$2,981.56, which is multiplied by the facility wage index of 0.8026 for an adjusted labor amount of \$2,393.00. The non-labor related portion is 40% of the APC rate, or \$1,987.70. The sum of the labor and non-labor portions is \$4,380.70. The Medicare facility specific amount of \$4,380.70, is multiplied by 200% for a MAR of \$8,761.40.
  - Procedure code 94770 has a status indicator S. As seen above this service is subject to the packaging with the primary J1 status indicator assigned to code 25609. Separate payment is not recommended.
  - Procedure code 96374 has a status indicator S. As seen above this service is subject to the packaging with the primary J1 status indicator assigned to code 25609. Separate payment is not recommended.
3. The total recommended reimbursement for the disputed services is \$8,761.40. The insurance carrier has paid \$8,739.34 leaving an amount due to the requestor of \$22.06. 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 \$22.06.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable) the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$22.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

		July 20, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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 §141.1(d).

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