TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Hunt Regional Medical Center

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-24-1600-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 22, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 9, 2023	80307	$0.00	$0.00
September 9, 2023	36415	$0.00	$0.00
September 9, 2023	80053	$0.00	$0.00
September 9, 2023	83690	$0.00	$0.00
September 9, 2023	85027	$0.00	$0.00
September 9, 2023	74177	$252.42	$0.00
September 9, 2023	71260	$114.14	$0.00
September 9, 2023	70450	$63.89	$0.00
September 9, 2023	99284	$0.00	$0.00
September 9, 2023	Q9967	$0.00	$0.00
September 9, 2023	J2405	$0.00	$0.00
	Total	$430.45	$0.00

Requestor's Position

"Based on our review, Hunt was underpaid by Helmsman Management Services LLC, Per the CMS Addendum B Fee Schedule, allowed CPT 74177, 71260, 70450 and 99284 at the facility rate is priced in the amount of $1,007.88, multiplied by 200%, results in a total allowed in the amount of $2,015.77."

Amount in Dispute: $430.45

Respondent's Position

"The carrier's initial EOB recommended payment of $1,585.32. The carrier's EOB explained the payments and the reductions. It is the carrier's position that the provider has been paid in full based upon the medical fee guidelines. The provider is not entitled to any additional payment."

Response submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 243 – The chare for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed .
- 4960 – Charge for this procedure exceeds the OPPS Q3 composite adjustment fee schedule allowance.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 56 – Significant, separately identifiable E/M service rendered.
- 4915 – The charge for the services represented by the Code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 847 – In accordance with OPPS guidelines, the billed revenue codes requires HCPCS/CPT coding. No separate payment is recommended for a non-package revenue code.

Issues

1. Is the carrier's reductions supported?

2. What rule is applicable to reimbursement?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of outpatient hospital services rendered in September of 2023. The insurance carrier reduced the disputed services as charges exceeding the OPPS fee schedule and packaging. The disputed services will be reviewed per applicable fee guidelines referenced below.

2. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, **regardless of billed amount**, if no contracted fee schedule exits that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the 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*.

   The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found implants are not applicable. The Medicare facility specific amount will be multiplied by 200 percent.

   The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 80307 is not in dispute.
- Procedure code 36415 is not in dispute.
- Procedure code 80053 is not in dispute.
- Procedure code 83690 is not in dispute.
- Procedure code 85027 is not in dispute.
- Procedure code 74177, 71260 and 70450 have a status indicator of Q3. Each code is packaged into single APC payment for these specific combinations of service. This code is assigned APC 8006. The OPPS Addendum A rate is $434.16 multiplied by 60% for an unadjusted labor amount of $260.50, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $248.20.

  The non-labor portion is 40% of the APC rate, or $173.66.

  The sum of the labor and non-labor portions is $421.86.

  The Medicare facility specific amount is $421.86 multiplied by 200% for a MAR of $843.72.
- Procedure code 99284 is subject to comprehensive packaging if 8 or more hours observation billed but as no observation hours were rendered this code has a status indicator of V and is assigned APC 5024. The OPPS Addendum A rate is $381.61 is multiplied by 60% for an unadjusted labor amount of $228.97, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $218.16.

  The non-labor portion is 40% of the APC rate, or $152.64.

  The sum of the labor and non-labor portions is $370.80.

  The Medicare facility specific amount is $370.80 multiplied by 200% for a MAR of $741.60.
- Procedure code Q9967 is not in dispute.
- Procedure code J2405 is not in dispute.

3. The total recommended reimbursement for the disputed services is $1,585.32. The insurance carrier paid $1,585.32. Additional payment is not recommended.

Conclusion

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

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 29, 2024 Date

Your Right to Appeal

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

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

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

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