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

TEXAS ORTHOPEDIC HOSPITAL
C/O HOLLAWAY & GUMBERT
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3926

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-9337-01

MFDR Date Received
June 10, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case. The carrier's position is incorrect and in violation of the Hospital Facility Fee Guideline for outpatient services."

Amount in Dispute: $13,385.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2008 to July 2, 2008	Outpatient Hospital Services	$13,385.36	$6,240.09

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, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. Per §133.307(d) "Responses to a request for MDR shall be legible and submitted to the Division and to the requestor in the form and manner prescribed by the Division. (1) Timeliness. The response will be deemed timely if received by the Division via mail service, personal delivery, or facsimile within 14 calendar days after the

date the respondent received the copy of the requestor's dispute. If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information. (2) Carrier Response. Upon receipt of the request, the carrier shall complete the required sections of the request form and provide any missing information not provided by the requestor and known to the carrier." The insurance carrier's Austin representative signed for and acknowledged receipt of a copy of the request for medical fee dispute resolution on June 22, 2009. The insurance carrier did not submit a response or a position statement for consideration in this dispute. The Division concludes that the insurance carrier has not met the requirements of §133.307(d). This decision is therefore based on the information available at the time of review.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
   - BL – THIS BILL WAS REVIEWED IN ACCORDANCE WITH A FIRST HEALTH OWNED CONTRACT. FOR QUESTIONS REGARDING THIS ANALYSIS, PLEASE CALL 800-370-0594
   - 181 – PAYMENT ADJUSTED BECAUSE THIS PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE.

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 reimbursement?

Findings

1. The insurance carrier reduced payment for disputed services with reason code BL – "THIS BILL WAS REVIEWED IN ACCORDANCE WITH A FIRST HEALTH OWNED CONTRACT. FOR QUESTIONS REGARDING THIS ANALYSIS, PLEASE CALL 800-370-0594." Review of the submitted information found no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 13, 2010, the Division requested the respondent to provide a copy of the referenced contract(s) between the alleged network and the requestor, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective May 25, 2008, 33 *Texas Register* 3954, 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 contract information submitted by the respondent finds that the parties referenced in the submitted information are unrelated to this dispute. No documentation was submitted to support a contractual fee arrangement between the health care provider and the insurance carrier. No documentation was found to support a contractual fee arrangement between the health care provider and an informal or voluntary network. No documentation was found to support that the insurance carrier, American Home Assurance Company, was entitled to access a contractual fee arrangement between the health care provider and any other party. The above payment reduction reason is not supported. The Division concludes that the disputed services are not subject to a contractual fee arrangement between the parties to this dispute. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 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.

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 J3490 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 J2250 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 J7050 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 J1885 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 J2001 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 J7120 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 A4217 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 $3.13. This amount multiplied by 2 units is $6.26. 125% of this amount is $7.83
- 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 82435 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 $6.42. 125% of this amount is $8.03
- Procedure code 84132 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 $6.42. 125% of this amount is $8.03
- Procedure code 84520 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 $5.51. 125% of this amount is $6.89
- Procedure code 82947 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 $5.48. 125% of this amount is $6.85
- Procedure code 84295 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 $6.72. 125% of this amount is $8.40

- Procedure code 85730 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 $8.38. 125% of this amount is $10.48
- Procedure code 85610 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 $5.49. 125% of this amount is $6.86
- Procedure code 85025 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 $10.86. 125% of this amount is $13.57
- Procedure code 85002 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 $6.29. 125% of this amount is $7.86
- Procedure code 85014 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 $3.31. 125% of this amount is $4.14
- Procedure code 72020 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 0.9997 yields an adjusted labor-related amount of $26.56. 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 $44.28 multiplied by 2 units is $88.56. 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 $88.56. This amount multiplied by 200% yields a MAR of $177.12.
- Procedure code 63030 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 208, which, per OPPS Addendum A, has a payment rate of $2,979.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,787.47. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of $1,786.93. The non-labor related portion is 40% of the APC rate or $1,191.65. The sum of the labor and non-labor related amounts is $2,978.58. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.1731. This ratio multiplied by the billed charge of $4,180.00 yields a cost of $723.56. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $2,978.58 divided by

the sum of all APC payments is 97.08%. The sum of all packaged costs is $1,480.97. The allocated portion of packaged costs is $1,437.72. This amount added to the service cost yields a total cost of $2,161.28. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $2,978.58. This amount multiplied by 200% yields a MAR of $5,957.16.

- Procedure code J1100 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 J0690 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 J2405 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 768, which, per OPPS Addendum A, has a payment rate of $0.26. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.16. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of $0.16. The non-labor related portion is 40% of the APC rate or $0.10. The sum of the labor and non-labor related amounts is $0.26 multiplied by 4 units is $1.04. 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 $1.04. This amount multiplied by 200% yields a MAR of $2.08.
- Procedure code J3010 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 C9113 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 $6,240.09. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $6,240.09. 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 $6,240.09.

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 $6,240.09, 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.