Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Orthopedic Surgical Hospital

Respondent Name
Hartford Insurance Company

MFDR Tracking Number
M4-14-3187-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 20, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are seeking separate reimbursement on implants. That request was in box 80 located on the UB form, Gallagher Bassett, paid zero on the implants."

Amount in Dispute: $4,232.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2013	Outpatient Hospital Services	$4,232.75	$4,232.75

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:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - W1 – Workers compensation state fee schedule adjustment
   - 94 – Processed in excess of charges
   - 16 – Claim/service lacks information or has submissions billing errors

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. What is the additional recommended payment for the implantable items in dispute?

4. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 30, 2014. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "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." Accordingly, this decision is based on the available information.
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 requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $55,470.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
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 72080 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 $45.95. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.57. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $27.35. The non-labor related portion is 40% of the APC rate or $18.38. The sum of the labor and non-labor related amounts is $45.73. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $45.73. This amount multiplied by 130% yields a MAR of $59.45.
   - Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.
   - Procedure code 63685 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 0039, which, per OPPS Addendum A, has a payment rate of $16,394.73. This amount multiplied by 60% yields an unadjusted labor-related amount of $9,836.84. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $9,758.15. The non-labor related portion is 40% of the APC rate or $6,557.89. The sum of the labor and non-labor related amounts is $16,316.04. 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 $2,025, 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 0.178. This ratio multiplied by the billed charge of $33,174.88 yields a cost of $5,905.13. 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 $16,316.04 divided by the sum of all APC payments is 70.57%. The sum of all packaged costs is $1,793.88. The allocated portion of packaged costs is $1,265.89. This amount added to the service cost yields a total cost of $7,171.02. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. 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 $16,316.04. This amount multiplied by 130% yields a MAR of $21,210.85.

- Procedure code 63655 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 0061, which, per OPPS Addendum A, has a payment rate of $6,792.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $4,075.22. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $4,042.62. The non-labor related portion is 40% of the APC rate or $2,716.82. The sum of the labor and non-labor related amounts is $6,759.44. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $6,759.44. This amount multiplied by 130% yields a MAR of $8,787.27.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
   - "ME RESTORSENSORE GEN" as identified in the itemized statement and labeled on the invoice as "37714 SENSORE" with a cost per unit of $16,500.00;
   - "ME RESORE RECHARGER" as identified in the itemized statement and labeled on the invoice as "PROG 37754 RESTORE SENSOR RECHARGE" with a cost per unit of $1,995.00;
   - "ME ACCES KIT 3550-31" as identified in the itemized statement and labeled on the invoice as "CABLE 355531MULTILEAD" with a cost per unit of $200.00;
   - "ME RESTORE PROGRAMME" as identified in the itemized statement and labeled on the invoice as "PROGRAMMER" with a cost per unit of $1,000.00;
   - "ME 16CH SURG LEAD" as identified in the itemized statement and labeled on the invoice as "LEAD 39286-65 SURGICAL LEAD" with a cost per unit of $5,580.00.

   The total net invoice amount (exclusive of rebates and discounts) is $25,275.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,877.50. The total recommended reimbursement amount for the implantable items is $27,152.50.
5. The total allowable reimbursement for the services in dispute is $57,210.07. The amount previously paid by the insurance carrier is $46,242.41. The requestor is seeking additional reimbursement in the amount of $4,232.75. This amount 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 $4,232.75.

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 $4,232.75, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		October , 2014
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 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request 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 §141.1(d).

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