



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

Pine Creek Medical Center

Respondent Name

Hartford Insurance Company

MFDR Tracking Number

M4-14-0181-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

September 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center was paid a total of \$14,511.91 on 6/21/13 however our facility was under paid per the APC rate."

Amount in Dispute: \$1,703.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Year to date we have paid the provider \$14,511.91 on this billing."

Response Submitted by: Hartford Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2012	Outpatient Hospital Services	\$1,703.77	\$1,703.77

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 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.
- 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - W3 – Additional payment made on appeal/reconsideration

- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

Issues

1. Is the claim adjustment code 45 supported?
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 Carrier reduced the medical bill using code 45 “Charges exceed fee schedule max allowable or contracted/legislated fee arrangement.” The Division cannot establish what type of contract – Informal or Voluntary pursuant to Texas Labor Code §413.011(d-1) through (d-3), or Health care Certified Network Texas §1305 – was allegedly accessed. The Division further notes that Texas Labor Code §413.011(d-1) through (d-3) regarding informal and voluntary networks for the type of service in this dispute expired on December 31, 2010. The division concludes that reduction code 45 is not supported, for that reason; the services in dispute will be reviewed pursuant to the applicable division 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 84703 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 \$10.64. 125% of this amount is \$13.30
 - Procedure code 29888 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 0052, which, per OPPS Addendum A, has a payment rate of \$6,212.62. This amount multiplied by 60% yields an unadjusted labor-related amount of \$3,727.57. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of \$3,606.42. The non-labor related portion is 40% of the APC rate or \$2,485.05. The sum of the labor and non-labor related amounts is \$6,091.47. 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 0.211. This ratio multiplied by the billed charge of \$15,200.00 yields a cost of \$3,207.20. 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 \$6,091.47 divided by the sum of all APC payments is 74.95%. The sum of all packaged costs is \$3,984.74. The allocated portion of packaged costs is \$2,986.54. This amount added to the service cost yields a total cost of \$6,193.74. 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 \$6,091.47. This amount multiplied by 200% yields a MAR of \$12,182.94.

- Procedure code 29879 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 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,076.45. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,245.87. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of \$1,205.38. The non-labor related portion is 40% of the APC rate or \$830.58. The sum of the labor and non-labor related amounts is \$2,035.96. 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, including multiple-procedure discount, is \$1,017.98. This amount multiplied by 200% yields a MAR of \$2,035.96.
 - Procedure code 29880 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 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,076.45. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,245.87. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of \$1,205.38. The non-labor related portion is 40% of the APC rate or \$830.58. The sum of the labor and non-labor related amounts is \$2,035.96. 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, including multiple-procedure discount, is \$1,017.98. This amount multiplied by 200% yields a MAR of \$2,035.96.
 - Per Medicare policy, procedure code 64447 may not be reported with procedure code 29879 billed on the same claim. No modifier is allowed. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
 - Procedure code 97001 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(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure has the highest practice expense for this date. The rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2012 is \$74.13. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of \$119.48
 - Procedure code 97116 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(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2012 is \$27.52. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of \$38.92
4. The total allowable reimbursement for the services in dispute is \$16,426.56. The amount previously paid by the insurance carrier is \$14,511.91. The requestor is seeking additional reimbursement in the amount of \$1,703.77. 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 \$1,703.77.

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 \$1,703.77, 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

Date

April , 2014

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.