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
Unified Health Services

Respondent Name
Birdville Independent School District

MFDR Tracking Number
M4-14-0531-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The bill for service dates 5/2/13 was denied by Edwards Claims Administration for no prior authorization for surgery performed. However, both the provider and Unified Health Services were told by the adjuster, "prior" to the surgery that the scheduled surgery for 5/3/13/ did not require a per-cert, as it was considered an emergency. "

Amount in Dispute: $9,715.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Starr Comprehensive Solutions, Inc. maintains the position that the requestor is not entitled to reimbursement as preauthorization was not requested and preauthorization was required."

Response Submitted by: Edwards Claims Administration, 1004 Marble Heights Drive, Marble Falls, TX 78654

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 2, 2013	Outpatient Hospital Services	$9,715.95	$9,715.95

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 §133.2 defines medical emergency.
3. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
5. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- 97 – Payment is included in the allowance for another service/procedure
- 197 – Payment denied/reduced for absence of precertification/authorization
- 193 – Original payment decision is being maintained. The claim was processed properly the first time

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
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 or denied disputed services with reason code 197 – "Payment denied/reduced for absence of precertification/authorization." 28 Texas Administrative Code 133.2 states in pertinent part, "(5) Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part;" Review of the submitted documentation finds;

    a. Diagnosis reported on medical bill is 813.42, "Other fractures of distal end of radius (alone**)."**

    b. Operative report, Indications, "This is a lady who fell on the job and sustained an injury to her wrist. She was found to have a comminuted intra-articular distal radius fracture. She was then cleared from a medical standpoint for operative intervention."

    The Division finds the services in dispute are required due to the above noted fracture which does meet the definition of emergency. The Carrier's decision is not supported. Therefore, the services in dispute will be reviewed per applicable 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 L3999 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). The fee listed for this code in the DMEPOS fee schedule is $0.00 as this is a miscellaneous code. This amount multiplied by 11 units is $0.00. This amount divided by the Medicare conversion factor of 34.023 and multiplied by the Division conversion factor of 55.3 yields a MAR of $0.00
    - Procedure code C1769 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 80048, date of service May 2, 2013, 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 $11.63. 125% of this amount is $14.54

- Procedure code 84703, date of service May 2, 2013, 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 $10.33. 125% of this amount is $12.91
- Procedure code 85027, date of service May 2, 2013, 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 $8.89. 125% of this amount is $11.11
- Procedure code 87081, date of service May 2, 2013, 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 $9.12. 125% of this amount is $11.40
- Procedure code 73100, date of service May 2, 2013, 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 0.9554 yields an adjusted labor-related amount of $26.34. 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 $44.72. 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 $44.72. This amount multiplied by 200% yields a MAR of $89.44.
- Procedure code 71020, date of service May 2, 2013, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator 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 0.9554 yields an adjusted labor-related amount of $26.34. 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 $44.72. 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 $44.72. This amount multiplied by 200% yields a MAR of $89.44.
- Procedure code 25608 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 0064, which, per OPPS Addendum A, has a payment rate of $5,040.30. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,024.18. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of $2,889.30. The non-labor related portion is 40% of the APC rate or $2,016.12. The sum of the labor and non-labor related amounts is $4,905.42 at 4 units, with multiple-procedure discount, is $12,263.55. 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 0.148. This ratio multiplied by the billed charge of $6,793.75 yields a cost of $1,005.48. 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 $12,263.55 divided by the sum of all APC payments is

98.86%. The sum of all packaged costs is $1,142.18. The allocated portion of packaged costs is $1,129.16. This amount added to the service cost yields a total cost of $2,134.64. 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 $12,263.55. This amount multiplied by 200% yields a MAR of $24,527.10.

- Procedure code 1830 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 J0131 has a status indicator of G, which denotes pass-through drugs and biologicals paid under OPPS; separate APC payment includes pass-through amount. These services are classified under APC 9283, which, per OPPS Addendum A, has a payment rate of $0.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.08. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of $0.08. The non-labor related portion is 40% of the APC rate or $0.05. The sum of the labor and non-labor related amounts is $0.13 multiplied by 200 units is $26.00. 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 $26.00. This amount multiplied by 200% yields a MAR of $52.00.
- 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 J2270 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 J1170 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 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 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 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 J2405 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 93005, date of service May 2, 2013, 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 0099, which, per OPPS Addendum A, has a payment rate of $26.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $16.00. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of $15.29. The non-labor related portion is 40% of the APC rate or $10.67. The sum of the labor and non-labor related amounts is $25.96. 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 is $25.96. This amount multiplied by 200% yields a MAR of $51.92.

4. The total allowable reimbursement for the services in dispute is $24,859.86. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $9,715.95. 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 $9,715.95.

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 $9,715.95, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 23, 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.