



**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**

Houston Orthopedic Hospital

**Respondent Name**

Amerisure Insurance Co

**MFDR Tracking Number**

M4-14-0956-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

November 25, 2013

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "This claim was denied for no authorization. Please review the authorization 1373670."

**Amount in Dispute:** \$8,400.26

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "It is Amerisure Insurance Company's position that no additional reimbursement is due. The bill has been paid per TDI/DWC maximum allowable reimbursement."

**Response Submitted by:** Amerisure Insurance, 5221 North O'Connor Boulevard, Suite 400, Irving, TX 75039-3711

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 24, 2013	Outpatient Hospital Services	\$8,400.26	\$1,534.51

**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 sets out the acute care hospital fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - W1 – Workers compensation state fee schedule adjustment
  - 197 – Payment denied/reduced for absence of precertification/preauthorization
  - W3 – Additional payment made on appeal/reconsideration

## 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. Is the requestor entitled to additional reimbursement?

## Findings

1. This dispute relates to outpatient hospital facility services 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.
2. 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 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 \$5,862.48. This amount multiplied by 60% yields an unadjusted labor-related amount of \$3,517.49. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of \$3,489.35. The non-labor related portion is 40% of the APC rate or \$2,344.99. The sum of the labor and non-labor related amounts is \$5,834.34. 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 \$18,161.05 yields a cost of \$3,232.67. 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 \$5,834.34 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$5,648.29. The allocated portion of packaged costs is \$5,648.29. This amount added to the service cost yields a total cost of \$8,880.96. 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 \$5,834.34. This amount multiplied by 200% yields a MAR of \$11,668.68.
- Procedure code 29881, is subject to the requirements of 28 Texas Administrative Code §134.600 (p) "Non-emergency health care requiring preauthorization includes: (12) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;" Review of the UniMed Direct Review Determination dated July 15, 2013 finds no request or approval for procedure code 29881. The carrier denied with reason code 197 – Payment denied/reduce for absence of precertification/preauthorization. The carrier's denial is supported. 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 50% 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 2013 is \$75.15. 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 \$122.15

3. The total allowable reimbursement for the services in dispute is \$11,790.83. This amount less the amount previously paid by the insurance carrier of \$10,256.32 leaves an amount due to the requestor of \$1,534.51. 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 \$1,534.51.

### ***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 \$1,534.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	October , 2015
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 MFDR 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.**