



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 and Address

BSA HOSPITAL LLC
PO BOX 752457
MEMPHIS TN 38175-2457

Respondent Name

Texas Mutual Insurance Co

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-14-1266-01

MFDR Date Received

January 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... your payment was not made according to the state of TX work comp fee schedule guidelines."

Amount in Dispute: \$241.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed, among others, codes 74177 and 71260 on the date above. Both of these codes have a status indicator of Q3, which means they may qualify for a composite payment under OPPSW, and in fact they do under APC 8006. That composite payment is \$21.12 (See OPPS Addendum A at CMS' website.) Further, under composite APC in this instance, no reimbursement should have been made for code 71260. Therefore, Texas Mutual is requesting a refund of the \$503.19 paid for code 71260. And no additional payment is due for code 74177."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2013	Outpatient Hospital Services	\$241.66	\$0.00

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

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE PLUS A MARKUP
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE
- 630 – THIS SERVICE IS PACKAGED WITH OTHER SERVICES PERFORMED ON THE SAME DATE AND REIMBURSEMENT IS BASED ON A SINGLE SERVICE
- CAC – 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.

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 reimbursement?

Findings

1. 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 is not applicable.
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 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 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 80053 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 \$14.53. 125% of this amount is \$18.16
 - Procedure code 86850 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of \$17.96. This amount multiplied by 60% yields an unadjusted labor-related amount of \$10.78. This amount multiplied by the annual wage index for this facility of 0.832 yields an adjusted labor-related amount of \$8.97. The non-labor related portion is 40% of the APC rate or \$7.18. The sum of the labor and non-labor related amounts is \$16.15. 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 \$16.15. This amount multiplied by 200% yields a MAR of \$32.30.
 - 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 \$10.69. 125% of this amount is \$13.36

- 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 \$8.25. 125% of this amount is \$10.31
- Procedure code 86900 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0409, which, per OPPS Addendum A, has a payment rate of \$9.67. This amount multiplied by 60% yields an unadjusted labor-related amount of \$5.80. This amount multiplied by the annual wage index for this facility of 0.832 yields an adjusted labor-related amount of \$4.83. The non-labor related portion is 40% of the APC rate or \$3.87. The sum of the labor and non-labor related amounts is \$8.70. 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 \$8.70. This amount multiplied by 200% yields a MAR of \$17.40.
- Procedure code 81001 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 \$4.35. 125% of this amount is \$5.44
- Procedure code 86901 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0409, which, per OPPS Addendum A, has a payment rate of \$9.67. This amount multiplied by 60% yields an unadjusted labor-related amount of \$5.80. This amount multiplied by the annual wage index for this facility of 0.832 yields an adjusted labor-related amount of \$4.83. The non-labor related portion is 40% of the APC rate or \$3.87. The sum of the labor and non-labor related amounts is \$8.70. 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 \$8.70. This amount multiplied by 200% yields a MAR of \$17.40.
- 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 \$5.40. 125% of this amount is \$6.75
- Procedure code 36415 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 \$3.00. 125% of this amount is \$3.75
- Procedure code 74177 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 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 71260 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 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.

- Procedure code 99284 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 V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$229.37. This amount multiplied by 60% yields an unadjusted labor-related amount of \$137.62. This amount multiplied by the annual wage index for this facility of 0.832 yields an adjusted labor-related amount of \$114.50. The non-labor related portion is 40% of the APC rate or \$91.75. The sum of the labor and non-labor related amounts is \$206.19. 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 \$206.19. This amount multiplied by 200% yields a MAR of \$412.38.
- Procedure code 96374 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 0437, which, per OPPS Addendum A, has a payment rate of \$39.13. This amount multiplied by 60% yields an unadjusted labor-related amount of \$23.48. This amount multiplied by the annual wage index for this facility of 0.832 yields an adjusted labor-related amount of \$19.54. The non-labor related portion is 40% of the APC rate or \$15.65. The sum of the labor and non-labor related amounts is \$35.19. 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 \$35.19. This amount multiplied by 200% yields a MAR of \$70.38.
- Procedure code 96375 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 0437, which, per OPPS Addendum A, has a payment rate of \$39.13. This amount multiplied by 60% yields an unadjusted labor-related amount of \$23.48. This amount multiplied by the annual wage index for this facility of 0.832 yields an adjusted labor-related amount of \$19.54. The non-labor related portion is 40% of the APC rate or \$15.65. The sum of the labor and non-labor related amounts is \$35.19. 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 \$35.19. This amount multiplied by 200% yields a MAR of \$70.38.
- Procedure code 96376 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 Q9967 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 codes 74177, and 71260 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8006, for computed tomography (CT) services including contrast. If a "without contrast" CT procedure is performed on the same date of service as a "with contrast" CT, APC 8006 is assigned rather than APC 8005. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator 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 8006, which, per OPPS Addendum A, has a payment rate of \$682.10. This amount multiplied by 60% yields an unadjusted labor-related amount of \$409.26. This amount multiplied by the annual wage index for this facility of 0.832 yields an adjusted labor-related amount of \$340.50. The non-labor related portion is 40% of the APC rate or \$272.84. The sum of the labor and non-labor related amounts is \$613.34. 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 \$613.34. This amount multiplied by 200% yields a MAR of \$1,226.68.

3. The total allowable reimbursement for the services in dispute is \$1,904.69. This amount less the amount previously paid by the insurance carrier of \$1,904.78 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be 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 \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized 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.

