



## **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**

TX HEALTH FORT WORTH  
3255 W PIONEER PKWY  
ARLINGTON TX 76013

#### **Respondent Name**

City of Fort Worth

#### **Carrier's Austin Representative Box**

Box Number 04

#### **MFDR Tracking Number**

M4-14-1318-01

#### **MFDR Date Received**

January 13, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility \$3,987.14 per the OUTLIER calculations."

**Amount in Dispute:** \$567.40

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "HCP continues to incorrectly calculated Outlier based on total billed charges rather than applying the tests to each APC payable line as defined by CMS for Outpatient bills. In summary, CorVel believes that the original review, and subsequent reevaluation, were both done correctly and consistently and that no further allowance is recommended at this time."

**Response Submitted by:** CorVel Corporation

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2013	Outpatient Hospital Services	\$567.40	\$567.40

### **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:

- 97 – Charge Included in another Charge or Service
- B15 – Procedure/Service is not paid separately
- RN – Not paid under OPPTS; services included in APC rate

## **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 OPPTS 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 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPTS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPTS, 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 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPTS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPTS, 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 81001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPTS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPTS, 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 73510 has a status indicator of X, which denotes ancillary services paid under OPPTS with separate APC payment. These services are classified under APC 0260, which, per OPPTS 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 72125 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPTS 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 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 76376 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 70450 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 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0616, which, per OPPS Addendum A, has a payment rate of \$344.71. This amount multiplied by 60% yields an unadjusted labor-related amount of \$206.83. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$197.61. The non-labor related portion is 40% of the APC rate or \$137.88. The sum of the labor and non-labor related amounts is \$335.49. 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 \$335.49. This amount multiplied by 200% yields a MAR of \$670.98.
- 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 Q9963 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 72125, 74177, 70450, 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 0.9554 yields an adjusted labor-related amount of \$391.01. 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 \$663.85. 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 0.208. This ratio multiplied by the billed charge of \$11,379.75 yields a cost of \$2,366.99. 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 \$663.85 divided by the sum of all APC payments is 63.58%. The sum of all packaged costs is \$1,482.52. The allocated portion of packaged costs is \$942.64. This amount added to the service cost yields a total cost of \$3,309.63. 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 \$2,147.89. 50% of this amount is \$1,073.95. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$1,737.80. This amount multiplied by 200% yields a MAR of \$3,475.59.
3. The total allowable reimbursement for the services in dispute is \$4,272.97. The amount previously paid by the insurance carrier is \$3,419.73. The requestor is seeking additional reimbursement in the amount of \$567.40. 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 \$567.40.

### ***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 \$567.40, 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

\_\_\_\_\_  
February 25, 2014  
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.**