Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Centennial Medical Center

Respondent Name
JC Penney Corp Inc

MFDR Tracking Number
M4-14-1749-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The only reason for the underpayment provided to date by the Carrier is the wrongful allegation by the Carrier that the billing does not contain necessary CPT codes. However, the claim was properly billed and correctly coded for processing and payment. Thus, the basis for the Carrier's denial is unsupported."

Amount in Dispute: $19,182.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows: The provider billed CPT 36583Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access. The operative reports supports CPT 62362.Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming. The attached operative report supports CPT 62362 further supporting our assertion of correct review. Please note the physician performing the procedure billed CPT 62362 further supporting our assertion of correct review."

Response Submitted by: Liberty Mutual Insurance, 303 Jesse Jewell Parkway, S.E., Suite 500, Gainesville, GA 30501

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2013	Outpatient Hospital Services	$19,182.24	$9,968.88

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 §134.203 sets out reimbursement guidelines for professional medical services.
3. 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

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X936 – CPT or HCPC is required to determine if services are payable
   - U634 – Procedure code not separately payable under a Medicare and or fee schedule guidelines
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
   - U263 – The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did submitted documentation support disputed service as billed?
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 denied the disputed service as U263 – "The code billed does not meet the level/description of the procedure performed/documented." 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the submitted medical bill contains code 36583 – "Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access." Review of the submitted documentation titled "Operative Report" states; "The patient had a transverse incision made in the right lower quadrant of abdomen through subcutaneous tissues to the plan of the old pain pump. The pain pump was externalized and it was detached from its spinal catheter." The carrier's denial is supported as the description of billed service in dispute is not reflected in operative report.
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 C1772 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 82962 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 $3.22. 125% of this amount is $4.03
   - 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 0.9675 yields an adjusted labor-related amount of $10.43. 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 $17.61. 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 0.162. This ratio multiplied by the billed charge of $218.92 yields a cost of $35.47. 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 $17.61 divided by the sum of all APC payments is 48.15%. The sum of all packaged costs is $9,966.71. The allocated portion of packaged costs is $4,799.39. This amount added to the service cost yields a total cost of $4,834.86. 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 $4,804.04. 50% of this amount is $2,402.02. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $2,419.63. This amount multiplied by 200% yields a MAR of $4,839.26.

- 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 0.9675 yields an adjusted labor-related amount of $5.61. 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 $9.48. 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 0.162. This ratio multiplied by the billed charge of $97.19 yields a cost of $15.74. 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 $9.48 divided by the sum of all APC payments is 25.92%. The sum of all packaged costs is $9,966.71. The allocated portion of packaged costs is $2,583.66. This amount added to the service cost yields a total cost of $2,599.40. 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 $2,582.81. 50% of this amount is $1,291.41. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $1,300.89. This amount multiplied by 200% yields a MAR of $2,601.77.
- 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 0.9675 yields an adjusted labor-related amount of $5.61. 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 $9.48. 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 0.162. This ratio multiplied by the billed charge of $108.44 yields a cost of $17.57. 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 $9.48 divided by the sum of all APC payments is 25.92%. The sum of all packaged costs is $9,966.71. The allocated portion of packaged costs is $2,583.66. This amount added to the service cost yields a total cost of $2,601.23. 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 $2,584.64. 50% of this amount is $1,292.32. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $1,301.80. This amount multiplied by 200% yields a MAR of $2,603.60.
- Procedure code J0330 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 J0360 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 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 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 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 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.

4. The total allowable reimbursement for the services in dispute is $10,048.66. This amount less the amount previously paid by the insurance carrier of $79.78 leaves an amount due to the requestor of $9,968.88. 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 $9,968.88.

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 $9,968.88, 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	May , 2014 Date
Signature	Medical Fee Dispute Resolution Manager	May , 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.