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
Victory Medical Center

Respondent Name
Liberty Mutual

MFDR Tracking Number
M4-14-2591-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the denial because according to the attached authorization letter from Liberty Mutual, CPT code 22852 – Removal of Thoracolumbar Hardware was deemed medically necessary and approved as an outpatient setting."

Amount in Dispute: $57,898.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider billed for procedures considered "Inpatient Only" in an outpatient setting without prior approval as required by §134.403(j)."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 8-9, 2013	Outpatient Hospital Services	$57,898.42	$8,898.93

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 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – Original payment decision is being maintained
   - U415 – Procedure code not reimbursable in an outpatient setting per state or Medicare guidelines

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 J2250, date of service November 8, 2013, 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 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 J0690, date of service November 8, 2013, 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 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 0.9657 yields an adjusted labor-related amount of $10.41. 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 $17.59. 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 $17.59. This amount multiplied by 200% yields a MAR of $35.18.
   - 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 0.9657 yields an adjusted labor-related amount of $5.60. 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 $9.47. 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 $9.47. This amount multiplied by 200% yields a MAR of $18.94.
   - Procedure code 82947 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 $5.39. 125% of this amount is $6.74
   - 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 0.9657 yields an adjusted labor-related amount of $5.60. 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 $9.47. 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 $9.47. This amount multiplied by 200% yields a MAR of $18.94.

- Procedure code 85049 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 $6.15. 125% of this amount is $7.69
- Procedure code 82565 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 $7.04. 125% of this amount is $8.80
- Procedure code 82374 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 $6.72. 125% of this amount is $8.40
- Procedure code 82435 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 $6.32. 125% of this amount is $7.90
- Procedure code 84132 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 $6.32. 125% of this amount is $7.90
- Procedure code 84295 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 $6.62. 125% of this amount is $8.28
- Procedure code 84520 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 $5.43. 125% of this amount is $6.79
- Procedure code 22852, date of service November 8, 2013, has a status indicator of C, which denotes inpatient procedures not paid under OPPS. 28 Texas Administrative Code 134.430 (j) states, “A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1). (1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include: (A) the reimbursement amount; (B) a description of the services to be performed under the

agreement; (C) any other provisions of the agreement; and (D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement. The requestor did not meet the requirements as set forth in 28 Texas Administrative Code §§ 134.403 (j) for performing this procedure in an alternative facility setting. Reimbursement is not recommended.

- Procedure code 94664, date of service November 8, 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 0077, which, per OPPS Addendum A, has a payment rate of $35.09. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.05. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of $20.33. The non-labor related portion is 40% of the APC rate or $14.04. The sum of the labor and non-labor related amounts is $34.37. 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 $34.37. This amount multiplied by 200% yields a MAR of $68.74.
- Procedure code 97530 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 25% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2013 is $33.24. 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 $39.40. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $38.00. The lesser amount is $38.00.
- Procedure code 97116 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 25% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2013 is $26.92. 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 $33.16. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $31.00. The lesser amount is $31.00.
- 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 $71.68. 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 $116.51. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $89.00. The lesser amount is $89.00.
- Procedure code 94761 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 94010, date of service November 8, 2013, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0368, which, per OPPS Addendum A, has a payment rate of $62.87. This amount multiplied by 60% yields an unadjusted labor-related amount of $37.72. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of $36.43. The non-labor related portion is 40% of the APC rate or $25.15. The sum of the labor and non-labor related amounts is $61.58 multiplied by 2 units is $123.16. 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. The OPPS Facility-Specific Impacts file does not list

a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2013 Default CCR as 0.206. This ratio multiplied by the billed charge of $225.00 yields a cost of $46.35. 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 $123.16 divided by the sum of all APC payments is 48.18%. The sum of all packaged costs is $11,654.87. The allocated portion of packaged costs is $5,614.98. This amount added to the service cost yields a total cost of $5,661.33. 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 $5,445.80. 50% of this amount is $2,722.90. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $2,846.06. This amount multiplied by 200% yields a MAR of $5,692.12.

- Procedure code 94760, date of service November 8, 2013, 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 94010 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0368, which, per OPPS Addendum A, has a payment rate of $62.87. This amount multiplied by 60% yields an unadjusted labor-related amount of $37.72. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of $36.43. The non-labor related portion is 40% of the APC rate or $25.15. The sum of the labor and non-labor related amounts is $61.58. 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. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2013 Default CCR as 0.206. This ratio multiplied by the billed charge of $105.00 yields a cost of $21.63. 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 $61.58 divided by the sum of all APC payments is 24.09%. The sum of all packaged costs is $11,654.87. The allocated portion of packaged costs is $2,807.49. This amount added to the service cost yields a total cost of $2,829.12. 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 $2,721.35. 50% of this amount is $1,360.68. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $1,422.26. This amount multiplied by 200% yields a MAR of $2,844.51.
- Procedure code J2405, date of service November 8, 2013, 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, date of service November 8, 2013, 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 J0330, date of service November 8, 2013, 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, date of service November 8, 2013, 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 J2765, date of service November 8, 2013, 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, date of service November 8, 2013, 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 J2765 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 J2310, date of service November 8, 2013, 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.

3. The total allowable reimbursement for the services in dispute is $8,898.93. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $8,898.93. 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 $8,898.93.

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 $8,898.93, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July , 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.