



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Texas Health of Arlington

**Respondent Name**

Starr Indemnity & Liability Co

**MFDR Tracking Number**

M4-14-3087-01

**Carrier's Austin Representative**

Box Number 09

**MFDR Date Received**

June 9, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "HRA has been hired by Texas Health of Arlington to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008..."

**Amount in Dispute:** \$76.14

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Written notification of medical fee dispute received however, no written position statement submitted.

#### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 27, 2013	Outpatient Hospital Services	\$76.14	\$76.14

#### 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:
  - W1 – Workers state fee schedule adjustment
  - 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. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 24<sup>th</sup>, 2014. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
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 is not applicable.
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 72125 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.
  - Procedure code 72128 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.
  - Procedure code 96372 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. The provider billed this procedure code with 2 units; however, review of the submitted documentation finds that only 1 unit is supported. Therefore, only 1 unit can be considered for 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 0.9549 yields an adjusted labor-related amount of \$22.42. 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 \$38.07. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$38.07 divided by the sum of all S and T APC payments of \$427.52 gives an APC payment ratio for this line of 0.089048, multiplied by the sum of all S and T line charges of \$310.50, yields a new charge amount of \$27.65 for the purpose of outlier calculation. 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 \$38.07. This amount multiplied by 200% yields a MAR of \$76.14.
  - Procedure code 99283 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0614, which, per OPPS Addendum A, has a payment rate of \$143.36. This amount multiplied by 60% yields an unadjusted labor-related amount of \$86.02. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$82.14. The non-labor related portion is 40% of the APC rate or \$57.34. The sum of the labor and non-labor related amounts is \$139.48. 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 \$139.48. This amount multiplied by 200% yields a MAR of

\$278.96.

- 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 J2930 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, 72128 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 8005, for computed tomography (CT) services without contrast. 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 OPSS with separate APC payment. These services are classified under APC 8005, which, per OPSS Addendum A, has a payment rate of \$400.28. This amount multiplied by 60% yields an unadjusted labor-related amount of \$240.17. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$229.34. The non-labor related portion is 40% of the APC rate or \$160.11. The sum of the labor and non-labor related amounts is \$389.45. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$389.45 divided by the sum of all S and T APC payments of \$427.52 gives an APC payment ratio for this line of 0.910952, multiplied by the sum of all S and T line charges of \$310.50, yields a new charge amount of \$282.85 for the purpose of outlier calculation. 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 \$389.45. This amount multiplied by 200% yields a MAR of \$778.90.
4. The total allowable reimbursement for the services in dispute is \$1,134.00. The amount previously paid by the insurance carrier is \$1,030.64. The requestor is seeking additional reimbursement in the amount of \$76.14. 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 \$76.14.

### ***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 \$76.14, 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

\_\_\_\_\_  
October , 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.**