



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

Texas Health HEB

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-14-3204-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 23, 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."

Amount in Dispute: \$595.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 22 – 26, 2013	Outpatient Hospital Services	\$595.58	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation Jurisdictional Fee Schedule
 - W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal

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 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.
 - Procedure code C1755 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 36415, date of service August 22, 2013, 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 80048, date of service August 22, 2013, 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 \$11.63. 125% of this amount is \$14.54
 - Procedure code 85025, date of service August 22, 2013, 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 49585 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0154, which, per OPPS Addendum A, has a payment rate of \$2,429.11. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,457.47. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$1,392.47. The non-labor related portion is 40% of the APC rate or \$971.64. The sum of the labor and non-labor related amounts is \$2,364.11. 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 0.231. This ratio multiplied by the billed charge of \$6,757.50 yields a cost of \$1,560.98. The

total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on the percentage of the total APC payment. The APC payment for these services of \$2,364.11 divided by the sum of all APC payments is 89.43%. The sum of all packaged costs is \$3,155.21. The allocated portion of packaged costs is \$2,821.83. This amount added to the service cost yields a total cost of \$4,382.81. 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 OPSS payment is \$245.62. 50% of this amount is \$122.81. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$2,486.92. This amount multiplied by 200% yields a MAR of \$4,973.84.

- Per CCI coding guidelines, procedure code 49505 may not be reported with procedure code 49505 billed on the same claim. Payment for this service is included in the reimbursement for the other services. Separate payment is not recommended.
 - Per CCI coding guidelines, procedure code 64450 may not be reported with procedure code 49585 billed on the same claim. Payment for this service is included in the reimbursement for the other services. Separate payment is not recommended.
 - Procedure code 76998 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 C9290 has a status indicator of G, which denotes pass-through drugs and biologicals paid under OPSS; separate APC payment includes pass-through amount. These services are classified under APC 9290, which, per OPSS Addendum A, has a payment rate of \$1.08. This amount multiplied by 60% yields an unadjusted labor-related amount of \$0.65. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$0.62. The non-labor related portion is 40% of the APC rate or \$0.43. The sum of the labor and non-labor related amounts is \$1.05 multiplied by 266 units is \$279.30. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is \$279.30. This amount multiplied by 200% yields a MAR of \$558.60.
 - Procedure code J1100 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 J1885 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 J2180 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 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 J2550 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.
3. The total allowable reimbursement for the services in dispute is \$5,564.09. This amount less the amount previously paid by the insurance carrier of \$7,092.32 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

Signature

Medical Fee Dispute Resolution Officer

October 15, 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.