Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
Liberty Mutual Insurance Co

MFDR Tracking Number
M4-15-0479-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…A request for reconsideration was submitted to Liberty Mutual on 8/27/14 advising that authorization was approved, and obtained. I have attached a copy of the authorization letter for their review. A denial EOB dated 9/11/14 "No payment recommended, not payable under OPPS."

Amount in Dispute: $7,841.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 63030 is an open procedure and provider documented procedure done percutaneous."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 16 – 17, 2014	Outpatient Hospital Services	$7,841.84	$7,841.84

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. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X263 – The code billed does not meet the level/description of the procedure performed/documented
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support the level of service?
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, X263 - "The code billed does not meet the level/description of the procedure performed/documented. Review of the submitted medical bill finds CPT code 63030 lay description is as follows; "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; interspace, lumbar. "In one method, a midline incision is made through a posterior (back) approach overlying the vertebrae. The incision is carried down through the tissue to the paravertebral muscles, which are retracted. The ligamentum flavum, which attaches the lamina from one vertebra to the lamina of another, may be partially or completely removed. Part of the lamina is removed on one side to allow access to the spinal cord. If a disc has ruptured, fragments or the part of the disc compressing the nerves are removed. A partial removal of a facet (facetectomy) or removal of bone around the foramen (foraminotomy) may also be performed to relieve pressure on the nerve. When decompression is complete, a free-fat graft may be placed to protect the nerve root. If the ligamentum flavum was not removed, it is placed over the fat graft. Paravertebral muscles are repositioned and the tissue is closed in layers. ***Note that approaches represented by these codes may be open as described above or endoscopically assisted***, which still requires open and direct visualization. In an endoscopically assisted approach, a small guide probe is inserted under fluoroscopic guidance. Using magnified video, as well as fluoroscopic guidance, the endoscope is manipulated through the foramen and into the spinal canal. Once the guide probe has been advanced to the surgical site, a slightly larger tube is manipulated over the guide probe. Surgical instruments are advanced through the hollow center of the tube. Herniated disc fragments are removed, and the disc is reconfigured to eliminate pressure on the nerve root(s). The endoscope is withdrawn."

   Review of the "Operative Report" dated April 16, 2014 states the following, "The incision, which was approximately 2 cm in length, was made just to the left of the midline and the probe, followed by the expanding tubes and the 18-mm operating tube were then placed and double checked on x-ray. The soft tissue was then removed from the posterior part of the lamina and the margin of the lamina was separated from the underlying ligament. The ligament was split longitudinally using a Penfield 4 and a small opening on the ligament was made for operating room purposes. The dissection was laterally. Check x-ray revealed that the incision was precisely in the right position and over the extruded disk…" The carrier's denial is not supported. The service in dispute will be reviewed per applicable rules and fee guidelines.

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 36415 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 80048 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 85007 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 76001 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 63030 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 0208, which, per OPPS Addendum A, has a payment rate of $4,003.31. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,401.99. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of $2,319.60. The non-labor related portion is 40% of the APC rate or $1,601.32. The sum of the labor and non-labor related amounts is $3,920.92. 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 $2,900, 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 0.192. This ratio multiplied by the billed charge of $12,600.00 yields a cost of $2,419.20. 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 $3,920.92 divided by the sum of all APC payments is 84.97%. The sum of all packaged costs is $4,679.42. The allocated portion of packaged costs is $3,975.96. This amount added to the service cost yields a total cost of $6,395.16. The cost of these services exceeds the annual fixed-dollar threshold of $2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $3,920.92. This amount multiplied by 200% yields a MAR of $7,841.84.

- Procedure code G0237 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 $39.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $23.61. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of $22.80. The non-labor related portion is 40% of the APC rate or $15.74. The sum of the labor and non-labor related amounts is $38.54 multiplied by 17 units is $655.18. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $655.18. This amount multiplied by 200% yields a MAR of $1,310.36.
- Procedure code G0238 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 $39.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $23.61. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of $22.80. The non-labor related portion is 40% of the APC rate or $15.74. The sum of the labor and non-labor related amounts is $38.54. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $38.54. This amount multiplied by 200% yields a MAR of $77.08.
- Per Medicare policy, procedure code 94010, date of service April 17, 2014, may not be reported with procedure code G0237 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code G0378, date of service April 17, 2014, 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 $9,229.28. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $7,841.84. 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 $7,841.84.

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 $7,841.84, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December , 2014
Signature	Medical Fee Dispute Resolution Officer	Date
		December , 2014
Signature	Medical Fee Dispute Resolution Manager	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.