



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

Baylor Surgical Hospital

Respondent Name

RCH Protect Coop

MFDR Tracking Number

M4-15-1617-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services."

Amount in Dispute: \$57,882.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has previously responded to this dispute on 2/17/2005. In addition: Per TDI rule 134.403 regarding reimbursement of implants the following information must be submitted for review: Copy of invoices Certification statement of actual cost of the implantables. Invoices were received but nowhere in the documentation to include the appeals was there any kind of certification statement therefore reimbursement for implants do not apply. After re-audit, carrier will pay for two procedures coded that were on the bill (63664 and 63685). This was applied on one of the implant lines as it is a large amount. This additional amount does not apply to the implants. Carrier otherwise maintains its position as outlined in the original response. "

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2014	Outpatient Hospital Services	\$57,882.26	\$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

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:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - P12 – Workers Compensation State Fee Schedule Adjustment
 - 28 – Claim/service lacks information which is needed for adjudication

Issues

1. Did the requestor support payment request for implantables?
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 services as 28 – “Claim/service lacks information which is needed for adjudication.” 28 Texas Administrative Code §134.403 (g) states, “Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission. (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.".” Review of the submitted documentation finds the Carrier’s denial is supported. No certification statement was found.
2. 28 Texas Administrative Code §134.403 states in pertinent part (f) The reimbursement calculation used for establishing the 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. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section. Review of the submitted information finds even though requestor sought separate reimbursement for the implants, the documentation requirements were not met. Therefore, the services in dispute will be calculated per applicable fee guidelines.
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 C1778 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 C1820 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 C1883 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 81025 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 87798 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 85576 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 63664 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 0040, which, per OPPS Addendum A, has a payment rate of \$4,626.50. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,775.90. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$2,650.71. The non-labor related portion is 40% of the APC rate or \$1,850.60. The sum of the labor and non-labor related amounts is \$4,501.31. 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 \$4,501.31. This amount multiplied by 200% yields a MAR of \$9,002.62.

- Procedure code 63685 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 0039, which, per OPPS Addendum A, has a payment rate of \$17,232.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$10,339.74. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$9,873.42. The non-labor related portion is 40% of the APC rate or \$6,893.16. The sum of the labor and non-labor related amounts is \$16,766.58. 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 \$2,900, 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 0.213. This ratio multiplied by the billed charge of \$13,294.00 yields a cost of \$2,831.62. 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 \$16,766.58 divided by the sum of all APC payments is 78.84%. The sum of all packaged costs is \$8,504.53. The allocated portion of packaged costs is \$6,704.56. This amount added to the service cost yields a total cost of \$9,536.18. 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 \$16,766.58. This amount multiplied by 200% yields a MAR of \$33,533.16.
 - 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 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.
4. The total allowable reimbursement for the services in dispute is \$42,535.78. This amount less the amount previously paid by the insurance carrier of \$52,261.98 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

March 25, 2015
Date

Signature

Medical Fee Dispute Resolution Manager

March 25, 2015
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.