



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Surgery Specialty Hospital of America

Respondent Name

Employers Preferred Ins Co

MFDR Tracking Number

M4-15-1642-01

Carrier's Austin Representative

Box Number 04

MFDR Date Received

February 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier did not make payment according to the Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula."

Amount in Dispute: \$230.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...attached is a copy of the amended payment EOR for you review, no further payment is due the provider..."

Response Submitted by: Coventry Workers' Comp Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28 – March 1, 2014	Outpatient Hospital Services	\$230.82	\$83.28

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 acute care hospital fee guideline for outpatient services.
- 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Original payment decision is being maintained
 - The charge for this procedure exceeds the fee schedule allowance
 - Procedure code not separately payable under Medicare and or Fee Schedule 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 additional reimbursement?

Findings

1. This dispute relates to outpatient hospital facility services 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 J8499 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
 - Procedure code J8499, date of service March 1, 2014, has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
 - 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 36415, date of service March 1, 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.
 - Procedure code 36415, date of service March 1, 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.
 - Procedure code 85025 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 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 0.9884 yields an adjusted labor-related amount of \$2,374.13. 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 \$3,975.45. 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 0.36. This ratio multiplied by the billed charge of \$21,997.00 yields a cost of \$7,918.92. 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 \$3,975.45 divided by the sum of all APC payments is 98.59%. The sum of all packaged costs is \$14,306.41. The allocated portion of packaged costs is \$14,104.29. This amount added to the service cost yields a total cost of \$22,023.21. 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 \$15,066.17. 50% of this amount is \$7,533.09. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$11,508.54. This amount multiplied by 200% yields a MAR of \$23,017.07.

- Procedure code 63035 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 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 50% 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 2014 is \$28.89. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$34.05
- Procedure code 97116, date of service March 1, 2014, 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 2014 is \$28.89. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$44.96
- 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 2014 is \$76.56. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$119.15

- Procedure code 94799 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0367, which, per OPPS Addendum A, has a payment rate of \$57.37. This amount multiplied by 60% yields an unadjusted labor-related amount of \$34.42. This amount multiplied by the annual wage index for this facility of 0.9884 yields an adjusted labor-related amount of \$34.02. The non-labor related portion is 40% of the APC rate or \$22.95. The sum of the labor and non-labor related amounts is \$56.97. 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 \$56.97. This amount multiplied by 200% yields a MAR of \$113.94.
 - Procedure code 94760 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 G0378 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 G8978 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
 - Procedure code G8979 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
 - Procedure code G8980 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
3. The total allowable reimbursement for the services in dispute is \$23,329.17. This amount less the amount previously paid by the insurance carrier of \$23,245.89 leaves an amount due to the requestor of \$83.28. 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 \$83.28

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 \$83.28 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	May , 2015 Date
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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 MFDR 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.