



# 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**

Texas Health Fort Worth

**Respondent Name**

Texas Mutual Insurance

**MFDR Tracking Number**

M4-15-1724-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

February 9, 2015

#### 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:** \$923.82

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed Texas Mutual for outpatient services provided on 5/22/14. Texas Mutual paid \$1,638.40 and believes no further payment is due."

**Response Submitted by:** Texas Mutual Insurance

#### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2014	Outpatient Hospital Services	\$923.82	\$923.82

#### 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:
  - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
  - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
  - 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate
  - 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. 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. The services in dispute do not contain charges for implantables. Therefore; these dates of service will be calculated as found below.
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 OPSS 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 82565 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 72125 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. 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. 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. The payment for composite services is calculated below.
  - Procedure code 74177 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. 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. 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. The payment for composite services is calculated below.
  - Procedure code 76376 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 70450 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. 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. 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. The payment for composite services is

calculated below.

- Procedure code 70486 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. 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. 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. The payment for composite services is calculated below.
- Procedure code 71260 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. 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. 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. The payment for composite services is calculated below.
- Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC ; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPSS with separate APC payment. These services are classified under APC 0615, which, per OPSS Addendum A, has a payment rate of \$293.71. This amount multiplied by 60% yields an unadjusted labor-related amount of \$176.23. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$168.28. The non-labor related portion is 40% of the APC rate or \$117.48. The sum of the labor and non-labor related amounts is \$285.76. 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 \$285.76. This amount multiplied by 200% yields a MAR of \$571.52.
- Procedure code Q9963 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 Q9967 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, 74177, 70450, 70486, and 71260 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 8006, for computed tomography (CT) services including contrast. If a “without contrast” CT procedure is performed on the same date of service as a “with contrast” CT, APC 8006 is assigned rather than APC 8005. 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 8006, which, per OPSS Addendum A, has a payment rate of \$548.28. This amount multiplied by 60% yields an unadjusted labor-related amount of \$328.97. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$314.13. The non-labor related portion is 40% of the APC rate or \$219.31. The sum of the labor and non-labor related amounts is \$533.44. 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 OPSS 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 OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.196. This ratio

multiplied by the billed charge of \$14,016.50 yields a cost of \$2,747.23. 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 \$533.44 divided by the sum of all APC payments is 65.12%. The sum of all packaged costs is \$382.79. The allocated portion of packaged costs is \$249.26. This amount added to the service cost yields a total cost of \$2,996.49. 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 OPSS payment is \$2,062.97. 50% of this amount is \$1,031.49. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$1,564.93. This amount multiplied by 200% yields a MAR of \$3,129.85.

3. The total allowable reimbursement for the services in dispute is \$3,701.37. The amount previously paid by the insurance carrier is \$1,638.40. The requestor is seeking additional reimbursement in the amount of \$923.82. 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 \$923.82.

### **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 \$923.82 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

March , 2015

### **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.**