



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

Texoma Medical Center

Respondent Name

TASB Risk Mgmt Fund

MFDR Tracking Number

M4-15-2228-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texoma Medical Center to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008 for..."

Amount in Dispute: \$4,960.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund timely and accurately reimbursed the provider according to rule 134.403 Outpatient Hospital Fee Guidelines."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 2, 2014, Outpatient Hospital Services, \$4,960.68, \$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 acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- P12 - Workers' compensation jurisdictional fee schedule adjustment
- 97 - Payment is included in the allowance for another service/procedure

- 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 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 96376 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 96376, date of service October 3, 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 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 80053 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 October 3, 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 80048, date of service October 3, 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 80061, date of service October 3, 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 82550 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 82550 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 82553 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 82962 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 84484 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.
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- Procedure code 82550, date of service October 3, 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 82553, date of service October 3, 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 82962, date of service October 3, 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 82962, date of service October 3, 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 83036, date of service October 3, 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 84484, date of service October 3, 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 85610 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 85730 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, date of service October 3, 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 81001 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 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS 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 X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified

under APC 0260, which, per OPSS Addendum A, has a payment rate of \$57.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$34.41. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$32.73. The non-labor related portion is 40% of the APC rate or \$22.94. The sum of the labor and non-labor related amounts is \$55.67. 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 \$55.67. This amount multiplied by 200% yields a MAR of \$111.34.

- 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 70496 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 70498 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 G8978, date of service October 3, 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 G8979, date of service October 3, 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 G8980, date of service October 3, 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 97116, date of service October 3, 2014, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPSS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPSS, 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 \$27.42. 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 \$32.71

- Procedure code 97001, date of service October 3, 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 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 \$73.00. 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 \$91.38
- Procedure code G8987, date of service October 3, 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 G8988, date of service October 3, 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 G8989, date of service October 3, 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 97530, date of service October 3, 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 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 \$33.45. 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 \$38.52
- Procedure code 97003, date of service October 3, 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 \$81.53. 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 \$126.88

- Procedure code 96374 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 0438, which, per OPPS Addendum A, has a payment rate of \$105.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$63.54. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$60.44. The non-labor related portion is 40% of the APC rate or \$42.36. The sum of the labor and non-labor related amounts is \$102.80. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$102.80 divided by the sum of all S and T APC payments of \$1,949.65 gives an APC payment ratio for this line of 0.052727, multiplied by the sum of all S and T line charges of \$12,684.50, yields a new charge amount of \$668.82 for the purpose of outlier calculation. 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 \$102.80. This amount multiplied by 200% yields a MAR of \$205.60.
- Procedure code 96375 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 0437, which, per OPPS Addendum A, has a payment rate of \$43.78. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.27. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$24.99. The non-labor related portion is 40% of the APC rate or \$17.51. The sum of the labor and non-labor related amounts is \$42.50. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$42.50 divided by the sum of all S and T APC payments of \$1,949.65 gives an APC payment ratio for this line of 0.021799, multiplied by the sum of all S and T line charges of \$12,684.50, yields a new charge amount of \$276.51 for the purpose of outlier calculation. 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 \$42.50. This amount multiplied by 200% yields a MAR of \$85.00.
- Procedure code 96376 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 99291 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8009; 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 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 0617, which, per OPPS Addendum A, has a payment rate of \$634.94. This amount multiplied by 60% yields an unadjusted labor-related amount of \$380.96. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$362.37. The non-labor related portion is 40% of the APC rate or \$253.98. The sum of the labor and non-labor related amounts is \$616.35. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item

outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$616.35 divided by the sum of all S and T APC payments of \$1,949.65 gives an APC payment ratio for this line of 0.316134, multiplied by the sum of all S and T line charges of \$12,684.50, yields a new charge amount of \$4,010.00 for the purpose of outlier calculation. 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 \$616.35. This amount multiplied by 200% yields a MAR of \$1,232.70.

- Procedure code 70551 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8007. 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 72141 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8007. 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 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 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 code 90656, date of service October 3, 2014, has a status indicator of L, which denotes influenza and pneumococcal pneumonia vaccine, not paid under OPPS; paid at reasonable cost. The insurance carrier allowed \$0.00. Review of the submitted information finds insufficient documentation to support a different reimbursement amount from the amount determined by the carrier, therefore no additional payment is recommended.
- Procedure code 93005, date of service October 3, 2014, 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 0099, which, per OPPS Addendum A, has a payment rate of \$27.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.27. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$15.48. The non-labor related portion is 40% of the APC rate or \$10.85. The sum of the labor and non-labor related amounts is \$26.33. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01;

therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$26.33 divided by the sum of all S and T APC payments of \$1,949.65 gives an APC payment ratio for this line of 0.013505, multiplied by the sum of all S and T line charges of \$12,684.50, yields a new charge amount of \$171.30 for the purpose of outlier calculation. 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 \$26.33. This amount multiplied by 200% yields a MAR of \$52.66.

- Procedure code 93005, date of service October 3, 2014, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPTS with separate APC payment. These services are classified under APC 0099, which, per OPPTS Addendum A, has a payment rate of \$27.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.27. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$15.48. The non-labor related portion is 40% of the APC rate or \$10.85. The sum of the labor and non-labor related amounts is \$26.33. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$26.33 divided by the sum of all S and T APC payments of \$1,949.65 gives an APC payment ratio for this line of 0.013505, multiplied by the sum of all S and T line charges of \$12,684.50, yields a new charge amount of \$171.30 for the purpose of outlier calculation. 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 \$26.33. This amount multiplied by 200% yields a MAR of \$52.66.
- 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 G0378, date of service October 3, 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 codes 70450, 70496, and 70498 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 OPPTS with separate APC payment. These services are classified under APC 8006, which, per OPPTS 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 0.9512 yields an adjusted labor-related amount of \$312.92. 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 \$532.23. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01;

therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$532.23 divided by the sum of all S and T APC payments of \$1,949.65 gives an APC payment ratio for this line of 0.272987, multiplied by the sum of all S and T line charges of \$12,684.50, yields a new charge amount of \$3,462.70 for the purpose of outlier calculation. 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 \$532.23. This amount multiplied by 200% yields a MAR of \$1,064.46.

- Procedure codes 70551 and 72141 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 8007, for magnetic resonance imaging (MRI) services without contrast. 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 OPPS with separate APC payment. These services are classified under APC 8007, which, per OPPS Addendum A, has a payment rate of \$621.30. This amount multiplied by 60% yields an unadjusted labor-related amount of \$372.78. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$354.59. The non-labor related portion is 40% of the APC rate or \$248.52. The sum of the labor and non-labor related amounts is \$603.11. 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 \$603.11. This amount multiplied by 200% yields a MAR of \$1,206.22.
3. The total allowable reimbursement for the services in dispute is \$4,300.13. This amount less the amount previously paid by the insurance carrier of \$4,745.76 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

April , 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 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.