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
Rio Grande Regional Hospital

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-15-3348-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is the position of the Provider that all charges relating to the admission of the claimant are due and payable and not subject to the improper reductions taken by the carrier in this case. The carrier's position is incorrect and in violation of the Hospital Facility Fee Guideline."

Amount in Dispute: $5,761.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payment s on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim. We previously paid CPT 29822-59-LTT at 200% CMS rate per Texas Fee Schedule. CPT 29826 was denied as included (U634). This is a packaged item and is Status N per OPPS. CPT 29827-LT was denied as not supported (X133). An arthroscopic debridement is supported of a rotator cuff tendon, but not a rotator cuff repair."

Response Submitted by: Hollaway & Gumbert, 3701 Kirby Drive, Suite 1288, Houston, TX 77098-3916

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2014	Outpatient Hospital Services	$5, 761.50	$1,416.96

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:
   - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
   - X133 – this charge was not reflected in the report as one of the procedures or services performed

- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 193 – Original payment decision is being maintained
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

Issues

1. Is the carrier's denial supported for code 29827?
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 X133 – "this charge was not reflected in the report as one of the procedures or services performed." Review of the submitted code 29827 finds;

    a. 29827 - Arthroscopy, shoulder, surgical; with rotator cuff repair

    b. Review of the submitted "Operative Report" shows; "There was a small bucket-handle tear in the anterior superior glenoid labrum with proving. This was debrided with a 3.5 shaver to the stable area. Viewing the rotator cuff, there was a partial 10-20% tear of the supraspinatus tendon. This was debrided with a 3.5 shave to a stable area, rest of the rotator cuff appeared to be intact. …Bursectomy was done with 3.5 shaver exposing the anterior undersurface of the acromion acrimioclavicular joint. Periosteum was removed off the anterior acromion. Using a 5.0 shaver and a 6.0 burr, acromioplasty was performed arthroscopically. Excellent decompression was obtained. The rotator cuff was inspected superiorly and found to be intact."

    c. "Operative Report Procedures" lists: 1. Arthroscopic debridement of glenoid labral tear and partial rotator cuff tear 2. Arthroscopic subacromial decompression.

    The Division finds the carrier's denial is supported. No additional payment can be recommended.

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;

    (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.

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 J2001 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 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.

- Per Medicare policy, procedure code 29827 may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 29826 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 29822 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 0041, which, per OPPS Addendum A, has a payment rate of $2,155.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,293.40. This amount multiplied by the annual wage index for this facility of 0.8426 yields an adjusted labor-related amount of $1,089.82. The non-labor related portion is 40% of the APC rate or $862.27. The sum of the labor and non-labor related amounts is $1,952.09. 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 0.086. This ratio multiplied by the billed charge of $27,065.00 yields a cost of $2,327.59. 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 $1,952.09 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $2,505.53. The allocated portion of packaged costs is $2,505.53. This amount added to the service cost yields a total cost of $4,833.12. 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 $1,416.96. 50% of this amount is $708.48. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $2,660.57. This amount multiplied by 200% yields a MAR of $5,321.14.
- Procedure code J0171 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 J1890 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 J2270 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 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 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 $5,321.14. This amount less the amount previously paid by the insurance carrier of $3,904.18 leaves an amount due to the requestor of $1,416.96. 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 $1,416.96.

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 $1,416.96, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	July , 2015
Signature	Medical Fee Dispute Resolution Officer	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.