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
Doctor's Hospital at Renaissance

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-15-3689-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAE shall be by applying the Medicare facility specific amount."

Amount in Dispute: $3,530.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has issued additional payment in the amount of $667.62 per the MAR."

Response Submitted by: AIG, 4100 Alpha Road, Suite 700, Dallas, Texas 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2 – 4, 2015	Outpatient Hospital Services	$3,530.91	$3,530.91

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 2 – The service is incidental with payment packaged or bundled into another service or APC payment
   - 3 – Workers' compensation jurisdictional fee schedule adjustment

- 4 – Payment has been determined using the Clinical Laboratory Fee Schedule
- 5 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
- 6 – The charge for lab test, which is a component of a panel test, cannot be billed separately when billed with other component tests of the same panel test. Payment has been made for the panel test.
- 7 – Workers Compensation State Fee Schedule Adjustment
- 8 – The allowance for the device intensive procedure was paid at an adjusted rate.
- 9 – The charge exceeds the APC rate for this service.
- 10 – Drug Screen charges not payable
- 11 – The payment for this service is always bundled into payment of other services and not paid as a stand-alone charge.
- 12 – A primary procedure has not been billed and/or recommended for payment

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 96361, date of service February 3, 2015, 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 0436, which, per OPPS Addendum A, has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55. This amount multiplied by the annual wage index for this facility of 0.8197 yields an adjusted labor-related amount of $16.03. The non-labor related portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor related amounts is $29.06. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $29.06. This amount multiplied by 200% yields a MAR of $58.12.
   - Procedure code 96365, date of service February 3, 2015, 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 0439, which, per OPPS Addendum A, has a payment rate of $173.59. This amount multiplied by 60% yields an unadjusted labor-related amount of $104.15.

This amount multiplied by the annual wage index for this facility of 0.8197 yields an adjusted labor-related amount of $85.37. The non-labor related portion is 40% of the APC rate or $69.44. The sum of the labor and non-labor related amounts is $154.81. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $154.81. This amount multiplied by 200% yields a MAR of $309.62.

- Procedure code 96366, date of service February 3, 2015, 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 0436, which, per OPPS Addendum A, has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55. This amount multiplied by the annual wage index for this facility of 0.8197 yields an adjusted labor-related amount of $16.03. The non-labor related portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor related amounts is $29.06. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $29.06. This amount multiplied by 200% yields a MAR of $58.12.
- Procedure code A4565, date of service February 3, 2015, 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 C1713, date of service February 3, 2015, 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 February 2, 2015, 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 February 3, 2015, 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 February 2, 2015, 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 G0434, date of service February 3, 2015, 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 February 2, 2015, 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 25575, date of service February 3, 2015, 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 0064, which, per OPPS Addendum A, has a payment rate of $5,569.47. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,341.68. This amount multiplied by the annual wage index for this facility of 0.8197 yields an adjusted labor-related amount of $2,739.18. The non-labor related portion is 40% of the APC rate or $2,227.79. The sum of the labor and non-labor related amounts is $4,966.97. 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 $2,775, 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 0.133. This ratio multiplied by the billed charge of $8,255.52 yields a cost of $1,097.98. 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 $4,966.97 divided by the sum of all APC payments is 93.62%. The sum of all packaged costs is $2,082.73. The allocated portion of packaged costs is

$1,949.84. This amount added to the service cost yields a total cost of $3,047.82. The cost of these services exceeds the annual fixed-dollar threshold of $2,775. 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 $4,966.97. This amount multiplied by 200% yields a MAR of $9,933.94.

- Procedure code J2405, date of service February 3, 2015, 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 J2765, date of service February 3, 2015, 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 J0690, date of service February 3, 2015, 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, date of service February 3, 2015, 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, date of service February 3, 2015, 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 J2710, date of service February 3, 2015, 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 J0131, date of service February 3, 2015, 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, date of service February 3, 2015, 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 J1885, date of service February 3, 2015, 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 J2001, date of service February 3, 2015, 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 J1100, date of service February 3, 2015, 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 J0330, date of service February 3, 2015, 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, date of service February 3, 2015, 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 J0131, date of service February 4, 2015, 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 February 3, 2015, 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 96374, date of service February 3, 2015, 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 $108.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $64.94.

This amount multiplied by the annual wage index for this facility of 0.8197 yields an adjusted labor-related amount of $53.23. The non-labor related portion is 40% of the APC rate or $43.30. The sum of the labor and non-labor related amounts is $96.53. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $96.53. This amount multiplied by 200% yields a MAR of $193.06.

- Procedure code 96375, date of service February 4, 2015, 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 0436, which, per OPPS Addendum A, has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55. This amount multiplied by the annual wage index for this facility of 0.8197 yields an adjusted labor-related amount of $16.03. The non-labor related portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor related amounts is $29.06. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $29.06. This amount multiplied by 200% yields a MAR of $58.12.

3. The total allowable reimbursement for the services in dispute is $10,610.98. The amount previously paid by the insurance carrier is $6,262.37. The requestor is seeking additional reimbursement in the amount of $3,530.91. 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 $3,530.91.

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 $3,530.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September , 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 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.