



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

Doctors Hospital at Renaissance

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-15-3712-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 13, 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 MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: \$2,455.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The attached Explanation of Bill Review Form shows why the carrier reduced the amount billed. Some of the charges are double-billed, as the procedure is included in the primary procedure, such as billing for acromioplasty and at the same time billing for tendon repair, both the right shoulder. Vein puncture, anesthesia, and surgical pathology should be included in the charge for tendon repair."

Response Submitted by: AIG, P.O. Box 25974, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12 -16, 2015	Outpatient Hospital Services	\$2,455.38	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 reimbursement guidelines for outpatient facility services provided in an acute care hospital.
- 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 – The charge exceeds the APC rate for this service
- 5 – Workers Compensation State Fee Schedule Adjustment
- 6 – Payment adjusted because the payer deems the information submitted does not support this man/frequency of services
- 7 – Your billing has been reviewed using the Correct Coding Initiative (CCI) edits.
- 8 – The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting as defined with the Medially Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid services
- 6 – This procedure is incidental to the primary procedure and does not warrant separate reimbursement

Issues

1. What is the applicable rule pertaining to reimbursement of the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is for outpatient facility services performed in an acute care hospital. 28 Texas Administrative Code 134.403 (f) states in pertinent part, 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 will be calculated as follows:

- Procedure code A4622, date of service March 16, 2015, is not a valid code or was not in effect on the date the services were provided. 28 Texas Administrative Code §134.403(d) requires that, for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule. Medicare payment policies require the accurate reporting of medical services using valid Healthcare Common Procedure Coding System (HCPCS) codes. Review of the submitted documentation finds that the procedure code reported is not recognized by Medicare as a valid HCPCS code for the date the services were rendered. This service does not meet the requirements of §134.403(d). Reimbursement cannot be recommended.
- Procedure code L1830, date of service March 16, 2015, 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(d)(1). The Medicare DMEPOS fee schedule amount for this code is \$78.30. 125% of this amount is \$97.88

- Procedure code C1713, date of service March 16, 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 March 12, 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 March 16, 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 80053, date of service March 12, 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 85027, date of service March 12, 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 81001, date of service March 12, 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 88304, date of service March 16, 2015, has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.
- 28 Texas Administrative Code 134.403 (d) states “For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section...”. Per Medicare CCI edits, procedure code 23130, date of service March 16, 2015, may not be reported with procedure code 23410 date of service March 16, 2015, billed on the same claim without a modifier and supporting documentation that details how this procedure was separate from the primary procedure. Review of the submitted documentation found no modifier or documentation that supports this was a separate and distinct procedure. Therefore the Division finds separate payment is not recommended.
- Procedure code 23410, date of service March 16, 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 0051, which, per OPSS Addendum A, has a payment rate of \$3,763.00. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,257.80. This amount multiplied by the annual wage index for this facility of 0.8197 yields an adjusted labor-related amount of \$1,850.72. The non-labor related portion is 40% of the APC rate or \$1,505.20. The sum of the labor and non-labor related amounts is \$3,355.92. 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 \$2,775, 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 0.133. This ratio multiplied by the billed charge of \$2,533.68 yields a cost of \$336.98. 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 \$3,355.92 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$2,442.97. The allocated portion of packaged costs is \$2,442.97. This amount added to the service cost yields a total cost of \$2,779.95. 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 \$3,355.92. This amount multiplied by 200% yields a MAR of \$6,711.84.

- Procedure code J2765, date of service March 16, 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 J2405, date of service March 16, 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 March 16, 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 J1200, date of service March 16, 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 March 16, 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 March 16, 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 March 16, 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 March 16, 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 J1030, date of service March 16, 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 93005, date of service March 12, 2015, has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.
2. The total allowable reimbursement for the services in dispute is \$6,809.72. This amount less the amount previously paid by the insurance carrier of \$6,851.80 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

Date

July , 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, 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.