



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

Pine Creek Medical Center

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-15-3745-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rule 134.403, the Medicare facility Specific reimbursement amount is multiplied by 200%. CPT code 63030 is reimbursed at 100% of \$7,985.48."

Amount in Dispute: \$7,985.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bill from provider Pine Creek Medical Center for DOS 1-15-15 was reviewed. Coventry, the Medical Bill Reviewing Company, stands by their denial... Denial is appropriate."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| January 15, 2015 | 63030 | \$7,985.48 | \$7,985.48 |

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:
 - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
 - W3 – (No narrative)
 - 193 – (No narrative)

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing." 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..."

Review of the submitted claim finds for the disputed service, Code 63030, no modifier is required. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 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;

The services in dispute will be calculated as follows;

- Procedure code 63030 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 0208, which, per OPPS Addendum A, has a payment rate of \$4,113.17. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,467.90. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$2,347.47. The non-labor related portion is 40% of the APC rate or \$1,645.27. The sum of the labor and non-labor related amounts is \$3,992.74. 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 0.191. This ratio multiplied by the billed charge of \$13,900.00 yields a cost of \$2,654.90. 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 \$3,992.74 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$2,326.87. The allocated portion of packaged costs is \$2,326.87. This amount added to the service cost yields a total cost of \$4,981.77. 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 \$3,992.74. This amount multiplied by 200% yields a MAR of \$7,985.48.
3. The total allowable reimbursement for the services in dispute is \$8,104.46. The amount previously paid by the insurance carrier is \$0.00. The requestor is seeking additional reimbursement in the amount of \$7,985.48. 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 \$7,985.48.

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 \$7,985.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature



Signature

Peggy Miller

Medical Fee Dispute Resolution Officer

August 13, 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, 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.