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
Forest Park Medical Center

Respondent Name
Republic Franklin Insurance Co

MFDR Tracking Number
M4-15-3971-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The payment rendered does not appear to be paid in accordance with the Texas Department of Insurance Medical Fee Guidelines."

Amount in Dispute: $14,270.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Respondent's position that the provider is not entitled to further payment as all charges have been paid appropriately."

Response Submitted by: Utica Nation Insurance Group, P.O. Box 5310, Binghamton, NY 13902-9955

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2014	Outpatient Hospital Services	$14,270.85	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - 59 – Processed based on multiple or concurrent procedure rules

- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

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. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 27650 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%. The provider billed this procedure code with 2 units; however, review of the submitted documentation finds that only 1 unit is supported by the modifier (LT). Therefore, only 1 unit can be considered for payment. These services are classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $3,781.64. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,268.98. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $2,158.25. The non-labor related portion is 40% of the APC rate or $1,512.66. The sum of the labor and non-labor related amounts is $3,670.91. 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. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2014 Default CCR as 0.197. This ratio multiplied by the billed charge of $19,000.00 yields a cost of $3,743.00. 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 $3,670.91 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $4,663.51. The allocated portion of packaged costs is $4,663.51. This amount added to the service cost yields a total cost of $8,406.51. 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 $1,982.42. 50% of this amount is $991.21. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $4,662.12. This amount multiplied by 200% yields a MAR of $9,324.24.
   - Per Medicare policy, procedure code 64450 may not be reported with procedure code 27650 billed on the same claim without a modifier and supporting documentation that details a separate and distinct service. Due to the lack of modifier and documentation, payment for this service is included in the payment for the primary procedure.

- 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.

3. The total allowable reimbursement for the services in dispute is $9,324.24. This amount less the amount previously paid by the insurance carrier of $10,729.15 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

		September 2, 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.