



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

Bayshore Medical Center

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-15-4157-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 25, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the claim was billed to Gallagher Bassett within 45 days of receiving information from the employer. The first claim was sent on 2-14-15 and a corrected claim was sent on 3-10-15."

Amount in Dispute: \$16,785.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bill in questions for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17 – 18, 2014	Outpatient Hospital Services	\$16,785.13	\$2,680.90

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:
 - 29 – The time limit for filing has expired

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
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 additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – “The time limit for filing has expired.” 28 Texas Administrative Code §§133.20(b) states,

Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

Review of the submitted information finds that:

- Requestor notes from January 21, 2015, “Provided w/c Ins Co. G. Bassett No clm*# only adj. nme...”
- Date reference on submitted CMS -1450, “03/05/2015

Based on the submitted information the Division finds the claim was submitted to the correct carrier with 95 days of notification of the correct workers' compensation insurance carrier. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 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.
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 J7050 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 J7040, date of service November 18, 2014, 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 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 82272 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 82800 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 84703 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 86850 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of \$12.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$7.27. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$7.04. The non-labor related portion is 40% of the APC rate or \$4.85. The sum of the labor and non-labor related amounts is \$11.89. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$11.89. This amount multiplied by 200% yields a MAR of \$23.78.
- Procedure code 86900 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of \$12.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$7.27. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$7.04. The non-labor related portion is 40% of the APC rate or \$4.85. The sum of the labor and non-labor related amounts is \$11.89. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$11.89. This amount multiplied by 200% yields a MAR of \$23.78.
- Procedure code 86901 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of \$12.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$7.27. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$7.04. The non-labor related portion is 40% of the APC rate or \$4.85. The sum of the labor and non-labor related amounts is \$11.89. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$11.89. This amount multiplied by 200% yields a MAR of \$23.78.
- Procedure code 86920 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0346, which, per OPPS Addendum A, has a payment rate of \$31.57. This amount multiplied by 60% yields an unadjusted labor-related amount of \$18.94. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$18.33. The non-labor related portion is 40% of the APC rate or \$12.63. The sum of the labor and non-labor related amounts is \$30.96 multiplied by 2 units is \$61.92. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount

is \$0. The total Medicare facility specific reimbursement amount for this line is \$61.92. This amount multiplied by 200% yields a MAR of \$123.84.

- Procedure code 86921 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of \$12.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$7.27. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$7.04. The non-labor related portion is 40% of the APC rate or \$4.85. The sum of the labor and non-labor related amounts is \$11.89 multiplied by 2 units is \$23.78. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$23.78. This amount multiplied by 200% yields a MAR of \$47.56.
- Procedure code 86922 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0346, which, per OPPS Addendum A, has a payment rate of \$31.57. This amount multiplied by 60% yields an unadjusted labor-related amount of \$18.94. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$18.33. The non-labor related portion is 40% of the APC rate or \$12.63. The sum of the labor and non-labor related amounts is \$30.96 multiplied by 2 units is \$61.92. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$61.92. This amount multiplied by 200% yields a MAR of \$123.84.
- Procedure code 85027 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 85610 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 85730 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 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 71020 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$57.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$34.41. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$33.31. The non-labor related portion is 40% of the APC rate or \$22.94. The sum of the labor and non-labor related amounts is \$56.25. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$56.25. This amount multiplied by 200% yields a MAR of \$112.50.
- Procedure code P9016 has a status indicator of R, which denotes blood and blood products paid separately under OPPS. These services are classified under APC 0954, which, per OPPS Addendum A, has a payment rate of \$190.71. This amount multiplied by 60% yields an unadjusted labor-related amount of \$114.43. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$110.76. The non-labor related portion is 40% of the APC rate or \$76.28. The sum of the labor and non-labor related amounts is \$187.04 multiplied by 2 units is \$374.08. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is \$374.08. This amount multiplied by 200% yields a MAR of \$748.16.

- Procedure code 36430, date of service November 18, 2014, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPSS with separate APC payment. These services are classified under APC 0110, which, per OPSS Addendum A, has a payment rate of \$285.17. This amount multiplied by 60% yields an unadjusted labor-related amount of \$171.10. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$165.61. The non-labor related portion is 40% of the APC rate or \$114.07. The sum of the labor and non-labor related amounts is \$279.68. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$279.68. This amount multiplied by 200% yields a MAR of \$559.36.
 - Procedure code 36000 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 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8003, for level II extended assessment and management services. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPSS with separate APC payment. These services are classified under APC 0616, which, per OPSS Addendum A, has a payment rate of \$455.93. This amount multiplied by 60% yields an unadjusted labor-related amount of \$273.56. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$264.78. The non-labor related portion is 40% of the APC rate or \$182.37. The sum of the labor and non-labor related amounts is \$447.15. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$447.15. This amount multiplied by 200% yields a MAR of \$894.30.
 - Procedure code J2916 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 November 18, 2014, 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 November 18, 2014, 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 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 \$2,680.90. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$2,680.90. 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 \$2,680.90.

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 \$2,680.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October , 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, 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.