



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

Texas Health of Stephenville

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-16-0551-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

November 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For all of the APC's the allowable amount due totaled is \$14,657.15. Based on their payment of \$14,158.79 for the APC a supplemental payment is still due of \$498.36 on the APC alone at this time."

Amount in Dispute: \$498.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The above calculations reflect the audit reimbursed in accordance with the Division Rules and payment policies for Outpatient and the Office acknowledges that an additional payment in the amount of \$181.85 is due. The office will however await a decision from the Division for final payment adjudication as the requestor is not in agreement with the aforementioned audit determinations. Furthermore, review of the requestor's dispute packet did not reveal substantiated evidence to support their rationale for an additional reimbursement of \$498.36 for services in dispute."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2015	27429, 79877	\$498.36	\$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.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 193 – Original payment decision is being maintained. The claim was processed properly the first time
 - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
 - W3 – Additional payment made on appeal/reconsideration

Issues

1. The insurance carrier denied disputed services with claim adjustment reason code 193 – “Original payment decision is being maintained. This claim was processed properly the first time.” 28 Texas Administrative Code §134.403 (d) requires that,

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, including the following paragraphs.

Review of the submitted information finds the services in question are related to Outpatient Hospital Services. The applicable Medicare payment policy is discussed below.

2. 28 Texas Administrative Code 134.403 (f) states,

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 submitted medical claim did not include a separate request for implantable reimbursement. The services in dispute found on the DWC060 will be reviewed as follows;

- Procedure code 27429 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 0052, which, per OPPS Addendum A, has a payment rate of \$6,322.79. This amount multiplied by 60% yields an unadjusted labor-related amount of \$3,793.67. This amount multiplied by the annual wage index for this facility of 0.9281 yields an adjusted labor-related amount of \$3,520.91. The non-labor related portion is 40% of the APC rate or \$2,529.12. The sum of the labor and non-labor related amounts is \$6,050.03. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated

accordingly. The APC payment for this service of \$6,050.03 divided by the sum of all S and T APC payments of \$7,079.41 gives an APC payment ratio for this line of 0.854595, multiplied by the sum of all S and T line charges of \$7,802.75, yields a new charge amount of \$6,668.19 for the purpose of outlier calculation. 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 0.258. This ratio multiplied by the billed charge of \$6,668.19 yields a cost of \$1,720.39. 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 \$6,050.03 divided by the sum of all APC payments is 85.46%. The sum of all packaged costs is \$3,807.51. The allocated portion of packaged costs is \$3,253.88. This amount added to the service cost yields a total cost of \$4,974.27. 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 \$6,050.03. This amount multiplied by 200% yields a MAR of \$12,100.06.

- Procedure code 29877 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 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,151.57. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,290.94. This amount multiplied by the annual wage index for this facility of 0.9281 yields an adjusted labor-related amount of \$1,198.12. The non-labor related portion is 40% of the APC rate or \$860.63. The sum of the labor and non-labor related amounts is \$2,058.75. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$1,029.38 divided by the sum of all S and T APC payments of \$7,079.41 gives an APC payment ratio for this line of 0.145405, multiplied by the sum of all S and T line charges of \$7,802.75, yields a new charge amount of \$1,134.56 for the purpose of outlier calculation. 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, including multiple-procedure discount, is \$1,029.38. This amount multiplied by 200% yields a MAR of \$2,058.73.

3. The total allowable reimbursement for the services in dispute is \$14,158.79. This amount less the amount previously paid by the insurance carrier of \$14,158.79 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

November , 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.