



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

M4-16-2616-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In closing, it is the position of the Hospital that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the Carrier in this case."

Amount in Dispute: \$1,455.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bill in question for manual review to determine if additional monies are owed."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21 – 22, 2015	Outpatient hospital services	\$1,455.46	\$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

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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. What is the Medicare payment rule?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are for Outpatient Hospital Services with dates of service August 21 - 22, 2015.
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 Medicare facility specific reimbursement amount is explained at, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf> as:

"The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.

To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted. You may also receive the following payments in addition to standard OPPS payments:"

The facility specific reimbursement amount is calculated as follows:

Payment rate found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider	40% non-labor related	Payment
71010	0260	S	\$59.37	\$59.37 X 60% = \$35.62	\$35.62 X 0.9679 = \$34.48	\$59.37 X 40% = \$23.75	\$34.48 + \$23.75 = \$58.23
96374	0438	S	\$108.24	\$108.24 X 60% = \$64.94	0.9679 X \$64.94 = \$62.86	\$108.24 X 40% = \$43.30	\$62.86 + \$43.30 = \$106.16
99285	0616	V	\$492.69	\$492.69 X 60% = \$295.61	0.9679 X \$295.61 = \$286.12	\$492.69 X 40% = \$197.08	\$286.12 + \$197.08 = \$483.20

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APGs as follows:

10.1.1 - Payment Status Indicators

An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment

system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

10.2 - APC Payment Groups

Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

The review of the following claim lines finds the following:

- Procedure code J1100 has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030 has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030, date of service August 22, 2015, has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80053 has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 82553 has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 83880 has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 84484 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85027 has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85007, date of service August 22, 2015, has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85027, date of service August 22, 2015, has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 87040 has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 87040, date of service August 22, 2015, has status indicator N payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 94664 has status indicator Q1 denoting 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.

- Procedure code 93005 has status indicator Q1 denoting 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.
- Procedure code G0378, date of service August 22, 2015, has status indicator N payment is packaged into the reimbursement for other services, including outliers.

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.

Review of the submitted medical claim finds implants were not requested. The maximum allowable reimbursement for the services in dispute is calculated as follows:

- Procedure code 71010 has status indicator S has a payment rate of \$59.37. The total Medicare facility specific reimbursement amount for this line is \$58.23. This amount multiplied by 200% yields a MAR of \$116.44.
 - Procedure code 96374, date of service August 22, 2015, has status indicator S has a payment rate of \$108.24. The total Medicare facility specific reimbursement amount for this line is \$106.16. This amount multiplied by 200% yields a MAR of \$212.32.
 - Procedure code 99285, date of service August 22, 2015, has a payment rate of \$492.69. The total Medicare facility specific reimbursement amount for this line is \$483.20. This amount multiplied by 200% yields a MAR of \$966.40.
3. The total allowable reimbursement for the services in dispute is \$1,295.16. This amount less the amount previously paid by the insurance carrier of \$1,295.16 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May , 2016

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.