



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Baylor Surgical Hospital

Respondent Name

Insurance Co of the State of PA

MFDR Tracking Number

M4-16-0058-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services."

Amount in Dispute: \$1,896.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. The carrier is in the process of a re-audit. The result may be that additional payment to the provider will be made. If the provider should receive the full amount it is requesting through medical dispute resolution, then the carrier requests that the provider withdraw its request for medial dispute resolution."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 24 – 27, 2015	88304, 62355, 62365, other outpatient services	\$1,896.32	\$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.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 23 – This procedure is not paid separately
 - 59 – Allowance based on multiple surgery guidelines

- 18 – Duplicate claim/service

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 23 – “This procedure is not paid separately” and 59 – “Allowance based on multiple surgery guidelines.” 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 88304 has a status indicator of Q1, which denotes 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. This code may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 62355 has a status indicator of Q2. Per Integrated OCE (IOCE), CMS Specifications V16.0 R1, Effective 01/01/2015
www.cms.gov/Medicare/Coding/OutpatientCodeEdit

12) Certain special HCPCS codes are always packaged when they appear with other specified services on the same day; however, they may be assigned to an APC and paid separately if there is none of the other specified service on the same day. Some codes are packaged in the presence of any payable code with status indicator of S, T, V or X (STVX-packaged, SI = Q1); other codes are packaged only in the presence of payable

codes with status indicator T (T-packaged, SI = Q2). The OCE will change the SI from Q(#) to N for packaging, or to the SI and APC specified for the code when separately payable. ***If there are multiple STVX and/or T packaged HCPCS codes on a specific date and no service with which the codes would be packaged on the same date, the code assigned to the APC with the highest payment rate will be paid...***

This code does not have the highest paid APC therefore, is packaged and not separately payable.

- Procedure code 62365 has a status indicator of Q2, which denotes T-packaged codes. This is the highest paid APC. These services are classified under APC 0221, which, per OPSS Addendum A, has a payment rate of \$2,947.54. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,768.52. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$1,682.22. The non-labor related portion is 40% of the APC rate or \$1,179.02. The sum of the labor and non-labor related amounts is \$2,861.24. 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 OPSS 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 OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.213. This ratio multiplied by the billed charge of \$10,658.00 yields a cost of \$2,270.15. The total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on the percentage of the total APC payment. The APC payment for these services of \$2,861.24 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$1,326.11. The allocated portion of packaged costs is \$1,326.11. This amount added to the service cost yields a total cost of \$3,596.26. 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 OPSS payment is \$0.00. The total Medicare facility specific reimbursement amount for this line is \$2,861.24. This amount multiplied by 200% yields a MAR of \$5,722.48.

3. The total allowable reimbursement for the services in dispute is \$5,722.48. This amount less the amount previously paid by the insurance carrier of \$7,047.38 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.