



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

Baylor Surgical Hospital

Respondent Name

Preferred Professional Insurance

MFDR Tracking Number

M4-16-1147-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

December 31, 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: \$21,657.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier maintains that it has correctly reimbursed the requestor as per the EORs submitted."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 1, 2015	Outpatient Hospital Services	\$21,657.64	\$3,969.54

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 59 – Processed based on multiple or concurrent procedure rules
 - P12 – Workers' compensation jurisdictional fee schedule adjustment
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is regarding 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 was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(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 §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are \$22,632.00. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

- Procedure code C1713 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 C1763 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 C1769 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 C9359 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 28200 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 0055, which, per OPPS Addendum A, has a payment rate of \$1,743.52. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,046.11. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$995.06. The non-labor related portion is 40% of the APC rate or \$697.41. The sum of the labor and non-labor related amounts is \$1,692.47. 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 is \$1,692.47. This amount multiplied by 130% yields a MAR of \$2,200.21.

- Procedure code 28322 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 0055, which, per OPPS Addendum A, has a payment rate of \$1,743.52. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,046.11. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$995.06. The non-labor related portion is 40% of the APC rate or \$697.41. The sum of the labor and non-labor related amounts is \$1,692.47. 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 0.213. This ratio multiplied by the billed charge of \$12,585.00 yields a cost of \$2,680.61. 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 \$846.24 divided by the sum of all APC payments is 33.33%. The sum of all packaged costs is \$1,032.75. The allocated portion of packaged costs is \$344.25. This amount added to the service cost yields a total cost of \$3,024.86. 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 \$1,543.94. 50% of this amount is \$771.97. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is \$1,618.21. This amount multiplied by 130% yields a MAR of \$2,103.67.

3. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:

- "DBM Putty 2.5 cc" as labeled on the invoice with a cost per unit of \$725.00 (4 units submitted on medical claim but only 2 units supported by invoice) at 2 units, for a total cost of \$1,450.00;
- "GWK 011 - Guide Wire Kit" as labeled on the invoice with a cost per unit of \$118.00;
- "Ovation 1ml" as labeled on the invoice with a cost per unit of \$4,500.00;
- "Cannulated Screw, " as labeled on the invoice with a cost per unit of \$180.00 (4 units submitted on medical claim but only 2 units supported by invoice) at 2 units, for a total cost of \$360.00.

The total net invoice amount (exclusive of rebates and discounts) is \$6,428.00. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$642.80. The total recommended reimbursement amount for the implantable items is \$7,070.80.

4. The total allowable reimbursement for the services in dispute is \$11,374.68. This amount less the amount previously paid by the insurance carrier of \$7,405.14 leaves an amount due to the requestor of \$3,969.54. 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 \$3,969.54.

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 \$3,969.54 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

January , 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, 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.