



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

LIBERTY INSURANCE CORPORATION

MFDR Tracking Number

M4-16-1474-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

February 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services. . . . Attached for your review is the UB, operative report, itemized statement, letter certifying cost of implants, available implant invoices and copy of our reconsideration request."

Amount in Dispute: \$11,933.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We previously paid CPT 63030 and 71020 at 200% of CMS' OPPS rate (\$4,050.37 @ 200%), per Texas Fee Schedule. Provider did request separate implant reimbursement to 3rd party on original submissions. However, the implants billed were not reimbursable. Surgiflo matrix (C1760 was included in procedure (X212). The Anulex Xelose (C1713) was explained per operative report, and disallowed as the charge for this procedure, material, and/or service is not normally billed. (X003). Amniotic membrane billed as C1762 was disallowed as the medical efficacy of this procedure has not been established. (X667) with message: Pre-authorization was required, but not requested for this service per DWC Rule 134.3600. (X170)."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 22, 2015 to July 31, 2015, Outpatient Hospital Services, \$11,933.89, \$3,979.24

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 §19.2009 sets out notice requirements for utilization review determinations.
2. 28 Texas Administrative Code §19.2010 sets out requirements prior to issuing adverse determinations.
3. 28 Texas Administrative Code §133.2 defines terms related to medical billing and bill processing.
4. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
5. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
6. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
  - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
  - MOPS – SERVICES REDUCED TO THE OUTPATIENT PERSPECTIVE PAYMENT SYSTEM (OPPS).
  - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
  - U634 – [No description of this claim adjustment code was found with the submitted materials.]
  - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
  - X003 – THE CHARGE FOR THIS PROCEDURE, MATERIAL, AND OR SERVICE IS NOT NORMALLY BILLED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H), (I), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH A TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE
  - X212 – THIS PROCEDURE IS INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THIS DATE.
  - X667 – THE MEDICAL EFFICACY OF THIS PROCEDURE HAS NOT BEEN ESTABLISHED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H), (I), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH A TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE SENT VIA FAX
  - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE.
  - Z652 – [No description of this claim adjustment code was found with the submitted materials.]
  - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)

## **Issues**

1. Did the insurance carrier submit the response in the form and manner prescribed by the Division?
2. Did the insurance carrier waive the right to deny medical necessity or appropriateness of the disputed services?
3. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. What is the additional recommended payment for the implantable items in dispute?
7. Is the requestor entitled to additional reimbursement?

## **Findings**

1. 28 Texas Administrative Code §133.307(d) requires that responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.

Subsection 133.307(d)(2) requires that the respondent shall provide any missing information not provided by the requestor and known to the respondent.

Paragraph 133.307(d)(2)(B) requires that the respondent shall also provide a paper copy of all initial and appeal EOBs related to the health care in dispute that were not submitted by the requestor.

Paragraph 133.307(d)(2)(D) further requires that the respondent provide a copy of any pertinent medical records or other documents relevant to the fee dispute not already provided by the requestor.

Paragraph (d)(1) provides that "If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information."

The respondent did not submit for review any missing documentation not provided by the requestor and known to the respondent, copies of explanations of benefits (EOBs), notices of determination made in utilization review (in accordance with the requirements of 28 Texas Administrative Code §19.2009) or documentation detailing the opportunity afforded the provider to discuss an adverse determination prior to issuing any determination (in accordance with the requirements of 28 Texas Administrative Code §19.2010) or other documentation to support the insurance carrier's payment reductions or denial reasons. Pursuant to §133.307(d)(1), this decision is based on the information available at the time of review.

2. The insurance carrier denied disputed services with claim adjustment reason codes:

- X003 – THE CHARGE FOR THIS PROCEDURE, MATERIAL, AND OR SERVICE IS NOT NORMALLY BILLED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H), (I), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH A TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE
- X667 – THE MEDICAL EFFICACY OF THIS PROCEDURE HAS NOT BEEN ESTABLISHED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H), (I), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH A TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE SENT VIA FAX

28 Texas Administrative Code §133.240(p) requires that all utilization review must be performed by an insurance carrier or utilization review agent that is registered or certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code Chapter 4201 and Texas Administrative Code Title 28, Chapter 19.

28 Texas Administrative Code §133.240(q) requires that:

When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

As stated above, the respondent did not submit documentation to support an adverse determination after retrospective utilization review (as defined in 28 Texas Administrative Code §133.2) in accordance with the requirements of 28 Texas Administrative Code §133.240 (p) and (q). Consequently, the respondent has waived the right to assert a denial based on medical necessity or appropriateness of the health care in dispute. These denial reasons are not supported.

3. 28 Texas Administrative Code §133.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

The respondent's position statement asserts, "Amniotic membrane billed as C1762 was disallowed . . . with message: Pre-authorization was required, but not requested for this service per DWC Rule 134.3600. (X170)." This denial reason does not appear on any of the supporting documentation submitted to the Division for review. As stated above, the respondent did not submit copies of EOBs or other information to support that these denial reasons were presented to the requestor prior to the date the request for MFDR was filed. Consequently, the respondent has waived the right to raise such denial reasons or defenses. Any such newly raised denial reasons or defenses shall not be considered in this review.

4. This dispute regards 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 implantable items are \$13,561.98. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating any outlier payments below.

5. 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 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
- Procedure code C1760 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
- Procedure code C1762 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
- Procedure code 80048, date of service July 22, 2015, has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services.
- Procedure code 86850 has status indicator Q1 denoting STVX-packaged codes; payment for this service is packaged with payment for any other procedures with status indicators S, T, V, or X that are billed for the same date. This code is separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 63030 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
- Procedure code 86900 has status indicator Q1 denoting STVX-packaged codes; payment for this service is packaged with payment for any other procedures with status indicators S, T, V, or X that are billed for the same date. This code is separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 63030 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
- Procedure code 86901 has status indicator Q1 denoting STVX-packaged codes; payment for this service is packaged with payment for any other procedures with status indicators S, T, V, or X that are billed for the same date. This code is separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met.

Payment for this service is included in the payment for procedure code 63030 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.

- Procedure code 87081 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
- Procedure code 85025, date of service July 22, 2015, has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services.
- Procedure code 85610, date of service July 22, 2015, has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services.
- Procedure code 88304 has status indicator Q1 denoting STVX-packaged codes; payment for this service is packaged with payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code is separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPSS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 63030 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
- Procedure code 71020, date of service July 22, 2015, has status indicator Q3 denoting conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 617; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line is paid separately. This line is assigned status indicator S denoting a significant procedure not subject to multiple-procedure discounting paid under OPSS with separate APC payment. These services are classified under APC 0260, which, per OPSS Addendum A, has a payment rate of \$59.37. This amount multiplied by 60% yields an unadjusted labor-related amount of \$35.62, multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$33.88. The non-labor related portion is 40% of the APC rate or \$23.75. The sum of the labor and non-labor related amounts is \$57.63. 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 \$57.63, multiplied by 130% is \$74.92.
- Procedure code 63030 has status indicator T denoting 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 service is paid at 100%. This service is classified under APC 0208, which, per OPSS Addendum A, has a payment rate of \$4,113.17, multiplied by 60% yields an unadjusted labor-related amount of \$2,467.90, multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$2,347.47. The non-labor related portion is 40% of the APC rate or \$1,645.27. The sum of the labor and non-labor related amounts is \$3,992.74. 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 \$11,723.00 yields a cost of \$2,497.00. The total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on percentage of total APC payment. The APC payment for these services of \$3,992.74, divided by the sum of all APC payments is 96.76%. The sum of all packaged costs is \$1,322.62. The allocated portion of packaged costs is \$1,279.74. This amount added to the service cost yields a total cost of \$3,776.74. The cost of these services exceeds the annual fixed-dollar threshold of \$2,775. However, the cost does not exceed 1.75 times the OPSS payment; therefore this service does not meet the criteria for additional outlier payment. The total Medicare facility specific reimbursement is \$3,992.74, multiplied by 130% yields a MAR of \$5,190.56.
- Procedure code C9290 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
- Procedure code J0330 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.

- Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
  - Procedure code J1170 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
  - Procedure code J2175 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
  - Procedure code J2270 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
  - Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
  - Procedure code J2765 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
  - Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
  - Procedure code J3260 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged with reimbursement for other services, including outliers.
  - Procedure code 93005, date of service July 22, 2015, has status indicator Q1 denoting STVX-packaged codes; payment for this service is packaged with payment for any other procedures with status indicators S, T, V, or X that are billed for the same date. This code is separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 71020 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
6. 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:
- Procedure code C1762 identified in the itemized statement as "GRAFT BONE 4CM X 4CM ALL" and labeled on the invoice as "AMNIOTIC MEMBRANE ALLOGRAFT 4 X 4" with a unit cost of \$4,500.00;
  - Procedure code C1713 identified in the itemized statement as "DEVICE REPAIR ANCHOR TIS" and labeled on the invoice as "Xclose Plus-TRS" with a unit cost of \$1,695.00.
  - Review of the submitted information finds the requestor did not submit documentation to support the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) for procedure code C1760, identified on the itemized statement as "MATRIX HEMOSTATIC 8 ML S." Payment cannot be recommended for this item.

The total net invoice amount (exclusive of rebates and discounts) is \$6,195.00. 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 \$619.50. The total recommended reimbursement amount for the implantable items is \$6,814.50.

7. The total allowable reimbursement for the services in dispute is \$12,079.98. This amount less the amount previously paid by the insurance carrier of \$8,100.74 leaves an amount due to the requestor of \$3,979.24. 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 \$3,979.24.

**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 \$3,979.24 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

_____	<u>Grayson Richardson</u>	<u>February 18, 2016</u>
Signature	Medical Fee Dispute Resolution Officer	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.**