



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 ORTHOPEDIC HOSPITAL

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-16-1581-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should have been paid in accordance with 28 T.A.C. § 134.403 . . . Using this formula, the hospital would have been entitled to \$12,203.54 in reimbursement. The Carrier only paid \$9,922.76. Therefore, the Hospital contends an additional \$2,280.78 remains owed."

Amount in Dispute: \$2,280.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Revenue code 270, 272 and 710 are denied correct as packaged . . . 27720 allowing \$8,937.41 (outlier was applied) . . . 20999 allowing \$1628.84 (multiple procedure reduction was applied) . . . Bill is priced correct."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 24, 2015, Outpatient Hospital Services, \$2,280.78, \$1,701.62

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 acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION
• BL – TO AVOID DUPLICATE BILL DENIAL. FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC
• BL – THIS BILL IS AQ RECONSIDERATION FO A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

- BL – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS BILL WAS REVIEWED IN ACCORDANCE WITH STATE GUIDELINES. USUAL AND CUSTOMARY POLICIES, OR THE PROVIDER'S PPO CONTRACT.
- BL – THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- B644 – [No explanation of this claim adjustment code was found with the submitted materials.]
- 59 – Processed based on multiple or concurrent procedure rules.
- P300 – [No explanation of this claim adjustment code was found with the submitted materials.]
- P1 – [No explanation of this claim adjustment code was found with the submitted materials.]
- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- W3 – Request for reconsideration.
- 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. Is the requestor entitled to additional reimbursement?

### Findings

1. 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 not requested.

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 27720 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 0063, which, per OPPS Addendum A, has a payment rate of \$4,228.40. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,537.04. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$2,455.60. The non-labor related portion is 40% of the APC rate or \$1,691.36. The sum of the labor and non-labor related amounts is \$4,146.96. 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 0.127. This ratio multiplied by the billed charge of \$3,322.00

yields a cost of \$421.89. 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 \$4,146.96 divided by the sum of all APC payments is 83.58%. The sum of all packaged costs is \$10,213.47. The allocated portion of packaged costs is \$8,536.91. This amount added to the service cost yields a total cost of \$8,958.80. 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 \$1,701.62. 50% of this amount is \$850.81. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$4,997.77. This amount multiplied by 200% yields a MAR of \$9,995.54.

- Procedure code 20999 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 0049, which, per OPPS Addendum A, has a payment rate of \$1,660.83. This amount multiplied by 60% yields an unadjusted labor-related amount of \$996.50. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$964.51. The non-labor related portion is 40% of the APC rate or \$664.33. The sum of the labor and non-labor related amounts is \$1,628.84. 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 \$814.42. This amount multiplied by 200% yields a MAR of \$1,628.84.

3. The total allowable reimbursement for the services in dispute is \$11,624.38. This amount less the amount previously paid by the insurance carrier of \$9,922.76 leaves an amount due to the requestor of \$1,701.62. 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 \$1,701.62.

### **ORDER**

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,701.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

_____	_____	_____
Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	March 31, 216 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.**