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
Clear Lake Regional Medical Center

Respondent Name
Hartford Underwriters Insurance

MFDR Tracking Number
M4-16-1590-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "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 take by the Carrier in this case."

Amount in Dispute: $1,768.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation found: The payable codes are 71010, 26727, 90471, 96361, 95375, and 99285. 76000 was denied due to CCI. The remaining codes are not payable. They are packaged and status = N & Q1 codes. The wage index for the provider is correct. Additional reimbursement is not recommended."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 7 – 8, 2015	Outpatient Hospital Services	$1,768.36	$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 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
- P12 – Workers' compensation jurisdiction fee schedule adjustment
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 4097 – Paid per fee schedule: Charge adjusted because statue dictates allowance is greater than provider's charge
- 193 – Original payment decision is being maintained. This claim was processed properly the first time
- 1115 – We find the original review to be accurate and are unable to recommend an additional allowance

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 243 – "The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed." 28 Texas Administrative Code §134.403(b)states in pertinent part,

   > 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…

   Review of the applicable Medicare payment policy, Outpatient Prospective Payment System (OPPS) found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html finds each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Review of the following submitted CPT codes finds the following:

   - Procedure code J2704, date of service August 8, 2015, 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 C1713, date of service August 8, 2015, 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 80053 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 85027 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 85610 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 73130 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.

- Per Medicare CCI edits, procedure code 76000, date of service August 8, 2015, may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare CCI edits, procedure code 90471 may not be reported with procedure code billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J0690 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 J1580 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 J1650 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 J2270 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 J2405 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 J3010 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 J7030 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 90714 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 J0131, date of service August 8, 2015, 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 J0690, date of service August 8, 2015, 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 J1170, date of service August 8, 2015, 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 J2405, date of service August 8, 2015, 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 J3010, date of service August 8, 2015, 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 93005 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 G0378 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.

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 claim finds separate reimbursement for implantables was not requested. Therefore, the remaining services in dispute will be reviewed per provisions of Rule 134.403(f)(1)(A).

- Procedure code 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $59.37. This amount multiplied by 60% yields an unadjusted labor-related amount of $35.62. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $34.48. 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 $58.23. 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 $58.23. This amount multiplied by 200% yields a MAR of $116.46.
- Procedure code 26727, date of service August 8, 2015, 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 0062, which, per OPPS Addendum A, has a payment rate of $2,042.65. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,225.59. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $1,186.25. The non-labor related portion is 40% of the APC rate or $817.06. The sum of the labor and non-labor related amounts is $2,003.31. 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 0.112. This ratio multiplied by the billed charge of $14,757.00 yields a cost of $1,652.78. 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 $2,003.31 divided by the sum of all APC payments is 69.97%. The sum of all packaged costs is $2,085.21. The allocated portion of packaged costs is $1,458.99. This amount added to the service cost yields a total cost of $3,111.77. 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 $0.00. The total Medicare facility specific reimbursement amount for this line is $2,003.31. This amount multiplied by 200% yields a MAR of $4,006.62.

- Procedure code 90471 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $53.54. This amount multiplied by 60% yields an unadjusted labor-related amount of $32.12. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $31.09. The non-labor related portion is 40% of the APC rate or $21.42. The sum of the labor and non-labor related amounts is $52.51. 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 $52.51. This amount multiplied by 200% yields a MAR of $105.02.

- Procedure code 96361 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $18.92. The non-labor related portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor related amounts is $31.95. 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 $31.95. This amount multiplied by 200% yields a MAR of $63.90.

- Procedure code 96374 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0438, which, per OPPS Addendum A, has a payment rate of $108.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $64.94. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $62.86. The non-labor related portion is 40% of the APC rate or $43.30. The sum of the labor and non-labor related amounts is $106.16. 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 $106.16. This amount multiplied by 200% yields a MAR of $212.32.

- Procedure code 96375 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $18.92. The non-labor related portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor related amounts is $31.95 multiplied by 4 units is $127.80. 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 $127.80. This amount multiplied by 200% yields a MAR of $255.60.

- Procedure code 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC ; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is

assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0616, which, per OPPS Addendum A, has a payment rate of $492.69. This amount multiplied by 60% yields an unadjusted labor-related amount of $295.61. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $286.12. The non-labor related portion is 40% of the APC rate or $197.08. The sum of the labor and non-labor related amounts is $483.20. 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 $483.20. This amount multiplied by 200% yields a MAR of $966.40.

3. The total allowable reimbursement for the services in dispute is $5,726.32. This amount less the amount previously paid by the insurance carrier of $5,726.32 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

		March 15, 2016
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, 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.