



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

Texas Health of SW Fort Worth

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-16-1624-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For all of the APC's the allowable amount due totaled is \$12,431.28. Based on their payment of \$8,436.62 for the APC a supplemental payment is still due of \$3,994.66 on the APC alone, at this time."

Amount in Dispute: \$3,994.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier position that the pharmacy, recovery room, anesthesia, sterile supply medical – surgical supplies, and the screw are bundled charges that should be included in the reimbursement for the arthroscopic procedure."

Response Submitted by: AIG, P.O. Box 25974, Shawnee, KS 66225

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: May 19 – 22, 2015, Outpatient Hospital Services, \$3,994.62, \$3,994.62

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:
- 1 – Workers' compensation jurisdictional fee schedule adjustment
- 5 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 6 – The service is incidental with payment packaged or bundled into another service or APC payment
- 7 – The charge exceeds the APC rate for this service

### 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(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.

Review of the submitted medical claim finds separate reimbursement for implantables was not requested. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

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 29827 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 0042, which, per OPPS Addendum A, has a payment rate of \$4,345.55. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,607.33. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$2,480.09. The non-labor related portion is 40% of the APC rate or \$1,738.22. The sum of the labor and non-labor related amounts is \$4,218.31. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$4,218.31 divided by the sum of all S and T APC payments of \$6,327.47 gives an APC

payment ratio for this line of 0.666666, multiplied by the sum of all S and T line charges of \$10,192.00, yields a new charge amount of \$6,794.66 for the purpose of outlier calculation. 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 \$4,218.31. This amount multiplied by 200% yields a MAR of \$8,436.62.

- Procedure code 29823 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 0042, which, per OPPS Addendum A, has a payment rate of \$4,345.55. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,607.33. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$2,480.09. The non-labor related portion is 40% of the APC rate or \$1,738.22. The sum of the labor and non-labor related amounts is \$4,218.31. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$2,109.16 divided by the sum of all S and T APC payments of \$6,327.47 gives an APC payment ratio for this line of 0.333334, multiplied by the sum of all S and T line charges of \$10,192.00, yields a new charge amount of \$3,397.34 for the purpose of outlier calculation. 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 \$2,109.16. This amount multiplied by 200% yields a MAR of \$4,218.32.

3. The total allowable reimbursement for the services in dispute is \$12,654.94. The amount previously paid by the insurance carrier is \$8,464.61. The requestor is seeking additional reimbursement in the amount of \$3,994.62. 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 \$3,994.62.

***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 \$3,994.62 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

\_\_\_\_\_  
March , 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.**