



# 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**

M4-16-1742-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

February 22, 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 taken by the Carrier in this case. The Carrier's position is incorrect and in violation of Rule §134.043."

**Amount in Dispute:** \$2,256.06

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "the carrier is in the process of reviewing the billing again. Carrier will supplement if it determines that any additional reimbursement is due. Carrier otherwise stands by its reductions."

**Response Submitted by:** Flahive, Ogden, & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2015 through September 4, 2015	Outpatient Hospital Services	\$2,256.06	\$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:
  - 246 – This non-payable code is for required reporting only
  - 59 – Processed based on multiple or concurrent procedure rules

- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
- 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. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 246 – “This non-payable code is for required reporting only”, 59 – “Processed based on multiple or concurrent procedure rules” and 97 – “The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated.” 28 Texas Administrative Code §134.403(d) 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 services in dispute finds the following submitted charges are subject to Medicare payment policy found in the Medicare Claims Processing manual, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPTS), Section 10.1.1 - Payment Status Indicators

*An OPPTS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPTS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPTS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPTS. Services with status indicator N are paid under the OPPTS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPTS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.*

*The full list of status indicators and their definitions is published in Addendum D1 of the OPPTS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPTS Addendum B.*

**and,**

#### Section 10.2 - APC Payment Groups

*Each HCPCS code for which separate payment is made under the OPPTS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPTS).*

Based on the above the following codes are reviewed as follows:

- Procedure code J1170, date of service September 3, 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 J2704, date of service September 3, 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 C1769, date of service September 3, 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 September 3, 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 80048, date of service August 10, 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 G8978, date of service September 4, 2015, has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code G8979, date of service September 4, 2015, has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code G8980, date of service September 4, 2015, has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code J0690, date of service September 3, 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 J1815, date of service September 3, 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 J2795, date of service September 3, 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 September 3, 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 J3490, date of service September 3, 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 September 4, 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 J1650, date of service September 4, 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, date of service August 10, 2015, 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.

The carrier's reduction/denial codes are supported. No additional payment can be recommended.

2. The remaining services in dispute are subject to 28 Texas Administrative Code §134.403 (f) which states in pertinent part,

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.

No request for implantables was found therefore the maximum allowable reimbursement is calculated as follows:

- Procedure code 28615, date of service September 3, 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 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. 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 \$4,146.96. This amount multiplied by 200% yields a MAR of \$8,293.92.
- Procedure code 28485, date of service September 3, 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 50%. 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. 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 \$2,073.48. This amount multiplied by 200% yields a MAR of \$4,146.96.
- Procedure code 28465, date of service September 3, 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 50%. 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. 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 \$2,073.48. This amount multiplied by 200% yields a MAR of \$4,146.96.

- Procedure code 97116, date of service September 4, 2015, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate for this code for 2015 is \$21.93. This amount divided by the Medicare conversion factor of 35.7547 and multiplied by the Division conversion factor of 56.2 yields a MAR of \$34.47
- Procedure code 97001, date of service September 4, 2015, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The Medicare rate for this code for 2015 is \$76.38. This amount divided by the Medicare conversion factor of 35.7547 and multiplied by the Division conversion factor of 56.2 yields a MAR of \$120.06

The carrier's reduction of 59 – "Processed based on multiple or concurrent procedure rules" is supported.

3. The total allowable reimbursement for the services in dispute is \$16,742.37. This amount less the amount previously paid by the insurance carrier of \$16,896.34 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 additional reimbursement for the services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
April 8, 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, 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.**