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 Orthopedic Hospital

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-16-1799-01

Carrier's Austin Representative
Box Number 15

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 §134.403."

Amount in Dispute: $3,475.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent paid a total of $3,257.68 for the total outpatient procedure performed on 3/11/15-3/12/15. Payment was calculated using the Medicare Fee Guidelines. No additional monies are owed to Requestor."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11 – 12, 2015	Outpatient Hospital Services	$3,475.18	$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
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 899 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor) component codes of comprehensive surgery: Musculoskeletal system procedure (20000 – 29999) has been disallowed
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. This claim was processed properly the first time
- 1014 – The attached billing has been re-evaluated at the request of the provider based on this re-evaluation. We find our original review to be correct. Therefore, no additional allowance appears to be warranted

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 J1885 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 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.
   - Per Medicare policy, procedure code 24147 may not be reported with procedure code 24120 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 J2250 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 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.

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 24120 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 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 is $1,628.84. This amount multiplied by 200% yields a MAR of $3,257.68.

3. The total allowable reimbursement for the services in dispute is $3,257.68. This amount less the amount previously paid by the insurance carrier of $3,257.68 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.