



**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**

Old Republic Insurance Co

**MFDR Tracking Number**

M4-16-2074-01

**Carrier's Austin Representative**

Box Number 447

**MFDR Date Received**

March 21, 2016

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "In closing, 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:** \$4,253.75

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question was escalated and the review has been finalized. Our bill audit company has determined additional monies are owed in the amount of \$2,110.13."

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 18 – 21, 2015	Outpatient hospital services	\$4,253.75	\$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:
  - P12 – Workers compensation jurisdictional fee schedule adjustment
  - W3 – Request for reconsideration
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
  - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

### **Issues**

1. What is the Medicare payment rule?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The services in dispute are for Outpatient Hospital Services with dates of service September 18 – 21, 2015. 28 Texas Administrative Code 134.403 (d) states,

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 with any additions or exceptions specified in this section, including the following paragraphs.

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APCS as follows:

#### **10.1.1 - Payment Status Indicators**

*An OPPS 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 OPPS 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 OPPS 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 OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS 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 OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.*

#### **10.2 - APC Payment Groups**

*Each HCPCS code for which separate payment is made under the OPPS 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 OPPS).*

Review of the submitted medical claim finds the following:

- Procedure code J1170 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2704 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code C1713 has status indicator N denoting packaged items and services with no separate APC payment.

- Per Medicare Correct Coding Initiatives Edits found at, <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> , procedure code 29895 may not be reported with procedure code 29898 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare Correct Coding Initiatives Edits found at, <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> , procedure code 29894 may not be reported with procedure code 29898 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 G8978 has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims.
- Procedure code G8979 has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims.
- Procedure code G8980 has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payments.

28 Texas Administrative Code 134.403 (f) 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 Medicare facility specific reimbursement amount is explained at, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsh.pdf> as:

*“The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service’s clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.*

*To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted. You may also receive the following payments in addition to standard OPPS payments:”*

The facility specific reimbursement amount is calculated as follows:

**Payment rate** found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider	40% non-labor related	Payment
27829	0063	T	\$4,228.40	\$4,228.40 X	\$2,537.04 X	\$4,228.40 X 40%	\$2,455.60 +

				60% = \$2,537.04	0.09679 = \$2,455.60	= \$1,691.36	\$1,691.36 = \$4,146.96
27784	0063	T	\$4,228.40	\$4,228.40 X 60% = \$2,537.04	\$2,537.04 X 0.09679 = \$2,455.60	\$4,228.40 X 40% = \$1,691.36	\$2,455.60 + \$1,691.36 = \$4,146.96 (multiple procedure discount x 50%) = \$2,073.48
29898	0041	T	\$2,151.57	\$2,151.57 X 60% = \$1,290.94	\$1,290.94 X 0.09679 = \$1,249.50	\$2,151.57 X 40% = \$860.63	\$1,249.50 + \$860.63 = \$2,110.13 (multiple procedure discount x 50%) = \$1,055.07
93005	0099	Q1	\$78.47	\$78.47 x 60% = \$47.08	\$47.08 x 0.09679 = \$45.57	\$78.47 x 40% = \$31.39	\$45.57 + \$31.39 = \$76.96

2. 28 Texas Administrative Code 134.403 (f) 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.

Review of the submitted medical claim finds implants were not requested. The maximum allowable reimbursement for the services in dispute listed on DWC 60 is calculated as follows:

- Procedure code 27829 has status indicator T denoting 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%. 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 27784 has status indicator T denoting 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%. 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 29898 has status indicator T denoting 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%. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$1,055.07. This amount multiplied by 200% yields a MAR of \$2,110.14.

- Procedure code 97001 has status indicator A denoting 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.
  - Procedure code 93005, date of service September 18, 2015, has status indicator Q1 denoting 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 total Medicare facility specific reimbursement amount for this line is \$76.96. This amount multiplied by 200% yields a MAR of \$153.92.
3. The total allowable reimbursement for the services in dispute is \$14,825.00. This amount less the amount previously paid by the insurance carrier of \$16,935.12 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	May , 2016 Date
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**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.**