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
Clear Lake Regional Medical Center

Respondent Name
TASB Risk MGMT Fund

MFDR Tracking Number
M4-16-2075-01

Carrier's Austin Representative
Box Number 47

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: $1,021.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TASBRMF has made payments in accordance with the above stated rule, no improper reductions, have been made as the provider indicates."

Response submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2015	Outpatient hospital services	$1,021.10	$1,021.10

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 – Additional payment made on appeal/reconsideration
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this

claim was processed properly
- 97 – Payment is included in the allowance for another service/procedure

Issues

1. Is the carrier's denial supported?
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 May 12, 2015. 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…" The carrier denied the following disputed services as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Review of the Medicare billing policy finds the following:

   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).

   10.2.1 - Composite APCs

   Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

The following services in dispute were reviewed as follows:

- 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 82553 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 82607 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 82746 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 83540 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 83550 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 84484 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 84703 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 85045 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 85660 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 87086 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 87186 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 81001 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 Q9967 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.

Pursuant to Rule 134.403(d) the carrier's denial is supported. No additional payment can be recommended.

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 Medicare facility specific reimbursement amount is explained at, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.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.*
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> *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:

The payment rate can be 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
70450, 71260, 72125, 74177	8006	S	$528.56	$528.56 X 60% = $317.14	0.9679 X $317.14 = $306.96	$528.56 X 40% = $211.42	$306.96 + $211.42 = $518.38
71010	260	S	$59.37	$59.37 X 60% = $35.62	0.9679 X $35.62 = $34.48	$59.37 X 40% = $23.75	$34.48 + $23.75 = $58.23
76830	266	S	$134.85	$134.85 X 60% = $80.91	0.9679 X $80.91 = $78.31	$134.85 X 40% = $53.94	$78.31 + $53.94 = $132.25
76856	266	S	$134.85	$134.85 X 60% = $80.91	0.9679 X $80.91 = $78.31	$134.85 X 40% = $53.94	$78.31 + $53.94 = $132.25
96374	438	S	$108.24	$108.24 X 60% = $64.94	0.9679 X $64.94 = $62.86	$108.24 X 40% = $43.30	$62.86 + $43.30 =

							$106.16
99284	615	V	$333.80	$333.80 X 60% = $200.28	0.9679 X $200.28 = $193.85	$333.80 X 40% = $133.52	$193.85 +$133.52 = $327.37

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.
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> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
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> (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 86850 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 86900 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 86901 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 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 70450 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. The payment for composite services is calculated below.
- Procedure code 71260 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. The payment for composite services is calculated below.
- Procedure code 72125 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. The payment for composite services is calculated below.
- Procedure code 74177 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. The payment for composite services is calculated below.
- 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; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may

be paid separately. 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 76830 the total Medicare facility specific reimbursement amount for this line is $132.25. This amount multiplied by 200% yields a MAR of $264.50.
- Procedure code 76856 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. The total Medicare facility specific reimbursement amount for this line is $132.25. This amount multiplied by 200% yields a MAR of $264.50.
- Procedure code 96374 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 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. The total Medicare facility specific reimbursement amount for this line is $327.37. This amount multiplied by 200% yields a MAR of $654.74.
- Procedure codes 70450, 71260, 72125, and 74177 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. These services are assigned to composite APC 8006.

  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 OPPS), Section 10.7 states, in pertinent part,

  > "B*eginning in CY 2005, for hospitals only, CMS implemented the use of a fixed-dollar threshold to better target outlier payments to complex and costly services that pose hospitals with significant financial risk. The current hospital outlier policy is calculated on a service basis using both fixed-dollar and multiple thresholds to determine outlier eligibility.*
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  > *The current outlier payment is determined by:*
  >
  > *• Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass-through status to payment for the associated procedure, by* ***multiplying the total charges for OPPS services by each hospital's overall CCR*** *(see §10.11.8 of this chapter); and*
  >
  > *• Determining whether the* ***total cost for a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year; and***
  >
  > *• If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPPS payment.*
  >
  > *The total cost of all packaged items and services, including the cost of uncoded revenue code lines with a revenue code status indicator of "N", that appear on a claim is allocated across all separately paid OPPS services that appear on the same claim. The proportional amount of total packaged cost allocated to each separately paid OPPS service is based on the percent of the APC payment rate for that service out of the total APC payment for all separately paid OPPS services on the claim."*

  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 $22,508.00 yields a cost of $2,520.90. 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 $518.38 divided by the sum of all APC payments is 50.03%. The sum of all packaged costs is $3,243.61. The allocated portion of packaged costs is $1,622.63. This amount added to the service cost yields a total cost of $4,143.53. 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 $3,236.36. 50% of this amount is $1,618.18. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $2,136.56. This amount multiplied by 200% yields a MAR of $4,273.12.

3. The total allowable reimbursement for the services in dispute is $5,389.91. The amount previously paid by the insurance carrier is $4,234.96. The requestor is seeking additional reimbursement in the amount of $1,021.10. 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 $1,021.10.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,021.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April , 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.