



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

West Houston Medical Center

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-16-2082-01

Carrier's Austin Representative

Box Number 19

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: \$1,187.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 18, 2015, Outpatient hospital services, \$1,187.74, \$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 adjus
 - W3 – Request for reconsideration
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - 97 – payment adjusted because 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 July 18, 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 – “Payment adjusted because 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:

- Procedure code J2270 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 73560 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 73562 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.
- Per National correct coding initiative policy manual found at, <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>, Chapter XI medicine evaluation and management services, CPT Codes 90000 – 99999 states in pertinent part,

Under OPSS, hospitals may report drug administration services (CPT codes 96360-96376)... with facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code.

Review of the submitted medical finds the 25 modifier was not included on the disputed claim lines and insufficient evidence was found to support a significant and separately identifiable service. Therefore, procedure code 96374 and 96375 is not separately payable.

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

10.2 - APC Payment Groups

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

Pursuant to Medicare payment policy and provisions of Rule 134.403 (d), the carrier's denial is supported.

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 (OPSS) reimbursement formula and factors as published annually in the Federal Register.

(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.

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 OPSS 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>

Geographic adjustment

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider	40% non-labor related	Payment
27560	0129	T	\$169.09	\$169.09 x 60% = \$101.45	0.9679 x \$101.45 = \$98.19	\$169.09 x 40% = \$67.64	\$98.19 + \$67.64 = \$165.83
99283	0614	V	\$198.39	\$198.39 x 60% = \$119.03	0.9679 x \$119.03 = \$115.21	\$198.39 x 40% = \$79.36	\$115.21 + \$79.36 = \$194.57

Review of the submitted medical claim finds implants were not requested nor is any outlier payment amount applicable. The maximum allowable reimbursement for the services in dispute is calculated as follows:

- Procedure code 99283 the total Medicare facility specific reimbursement amount for this line is \$194.57. This amount multiplied by 200% yields a MAR of \$389.14.
 - Procedure code 27560 the total Medicare facility specific reimbursement amount for this line is \$165.83. This amount multiplied by 200% yields a MAR of \$331.66.
3. The total allowable reimbursement for the services in dispute is \$720.80. This amount less the amount previously paid by the insurance carrier of \$1,298.06 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 , 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.