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
Bayshore Medical Center

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-16-2311-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 7, 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."

Amount in Dispute: $2,425.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As demonstrated in the above tables, all payable codes were paid in accordance with the fee guidelines; codes denied per OCE edits (facility version of CCI Edits) were done as no supporting documentation was included that would override the edit denial; N status HCPCS codes and Packed REV codes were all denied according to OPPS guidelines. All services were reviewed in accordance with rule §134.403."

Response Submitted by: Service Lloyds

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2015	Outpatient Hospital Services	$2,425.13	$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 outpatient hospital facility fee Guidelines.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – Allowance based on Multiple Surgery Guidelines

- P12 – Workers' Compensation State Fee Schedule Adjustment
- 236 – This proc or proc/mod combo not compatible w/another proc on same day
- P14 – Payment is included in another svc/procedure occurring on same day
- 234 – This procedure is not paid separately
- R79 – CCI; Standards of medical/Surgical Practice
- RD9 – Multiple Procedure/3rd of Subsequent (50%)
- W3 – Appeal/reconsideration
- R84 – CCI; most extensive procedures

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 P14 – "Payment is included in another svc/procedure occurring on same day" and R79 – "CCI; Standards of medical/Surgical Practice." 28 Texas Administrative Code 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 Medicare Claims processing Manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf, defines the terms, "Status Indicators" and "APC Payment Groups" 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).*

The Medicare payment policy regarding the services in dispute is as follows:

- Procedure code J1170 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J7030 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0434 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80048 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80320 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 85027 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 73110 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 73130 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 Medicare CCI edits, procedure code 25000 may not be reported with procedure code 25270 billed on the same claim. Payment for this service is included in the payment for the primary procedure.
- Per Medicare CCI edits, procedure code 64721 may not be reported with procedure code 25270 billed on the same claim. Payment for this service is included in the payment for the primary procedure.
- Per Medicare CCI edits, procedure code 20103 may not be reported with procedure code 11012 billed on the same claim. Payment for this service is included in the payment for the primary procedure.
- Per Medicare CCI edits, procedure code 96375 may not be reported with procedure code 25000 billed on the same claim. Payment for this service is included in the payment for the primary procedure.
- Procedure code J0690 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 90714 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0378 has a status indicator of N, payment is packaged into the reimbursement for other services, including outliers.

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.

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
11012	0020	T	$826.58 Subject to Multiple Procedure Discounting Paid at 50% = $413.29	$413.29 x 60% = $247.97	0.9679 x $247.97 = $240.01	$413.29 x 40% = $165.31	$240.01 + $165.31 = $405.32
25260	0050	T	$2,602.13 @50% = $1,301.06	$1,301.06 x 60% = $780.64	0.9679 x $780.64 = $755.58	$1,301.06 x 40% = $520.42	$755.58 + $520.42 = $1,276.00
25270	0050	T	$2,602.13 @50% = $1,301.06	$1,301.06 x 60% = $780.64	0.9679 x $780.64 = $755.58	$1,301.06 x 40% = $520.42	$755.58 + $520.42 = $1,276.00
25320	0051	T	$3,763.00 @50% = $1,881.50	$1,881.50 x 60% = $1,128.90	0.9679 x $1,128.90 = $1,092.66	$1,881.50 x 40% = $752.60	$1,092.66 + $752.60 = $1,845.26
25628	0063	T	$4,228.40 @100%	$4,228.40 x 60% = $2,537.04	0.9679 x $2,537.04 = $2,455.60	$4,228.40 x 40% = $1,691.36	$2,455.60 + $1,691.36 = $4,146.96
76000	0272	S	$159.53	$159.53 x 60% = $95.72	0.9679 x $95.72 = $92.65	$159.53 x 40% = $63.81	$92.65 + $63.81 = $156.46
90471	0437	S	$53.54	$53.54 x 60% = $32.12	0.9679 x $32.12 = $31.09	$53.54 x 40% = $ 21.42	$31.09 + $21.42 = $52.51
96374	0438	S	$108.24	$108.24 x 60% = $64.94	0.9679 x $64.94 = $62.85	$108.24 x 40% = $43.30	$62.85 + $43.30 = $106.15
99285	0616	Q3	$492.69	$492.69 x 60% = $295.61	0.9679 x $295.61 = $286.12	$492.69 x 40% = $197.08	$286.12 + $197.08 = $483.20

3. 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 76000, the total Medicare facility specific reimbursement amount for this line is $156.46. This amount multiplied by 200% yields a MAR of $312.92.
- Procedure code 25628 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%. 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 25320 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. This procedure is paid at 50%. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,845.26. This amount multiplied by 200% yields a MAR of $3,690.52.
- Procedure code 25260 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. This procedure is paid at 50%. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,276.00. This amount multiplied by 200% yields a MAR of $2,552.02.
- Procedure code 25270 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. This procedure is paid at 50%. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,276.00. This amount multiplied by 200% yields a MAR of $2,552.00.
- Procedure code 11012 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. This procedure is paid at 50%. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $405.32. This amount multiplied by 200% yields a MAR of $810.64.
- Procedure code 90471, the total Medicare facility specific reimbursement amount for this line is $52.51. This amount multiplied by 200% yields a MAR of $105.02.
- 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 99285 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. These services are classified under APC 0616, which, per OPPS Addendum A, has a payment rate of $492.69. The total Medicare facility specific reimbursement amount for this line is $483.20. This amount multiplied by 200% yields a MAR of $966.40.

4.

5. The total allowable reimbursement for the services in dispute is $19,465.74. This amount less the amount previously paid by the insurance carrier of $19,727.49 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

		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.