



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

Houston ISD

MFDR Tracking Number

M4-16-2546-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

April 22, 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: \$1,455.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill was processed correctly the first time submitted on EOR 819124, 05-13-2015."

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 16 - 18, 2015, Outpatient hospital services, \$1,455.45, \$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.
- 799 - Allowance has been adjusted in accordance with OPPS multiple procedure rule
- P12 - Workers compensation jurisdictional fee schedule adjustment
- 949 - Denied after reconsideration. Documentation submitted does not justify additional

reimbursement

- 16 – Claim/service lacks information which is needed for adjudication

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 March 16 – 18, 2015. 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 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.

Review of the submitted medical claims finds the following regarding the services in dispute:

- Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J7030, date of service March 17, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J7120, date of service March 17, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80048 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80048, date of service March 17, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80048, date of service March 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85027 has status indicator N denoting packaged items and services with no separate APC payment.

- Procedure code 85027, date of service March 17, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85027, date of service March 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J1885 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J0690, date of service March 17, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J0690, date of service March 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code G0378 has status indicator N denoting packaged items and services with no separate APC payment.

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:”

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 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
11012	0020	T	\$826.58	\$826.58 X 60% = \$495.95	\$495.95 X 0.9679 = \$480.03	\$826.58 X 40% = \$330.63	\$480.03+ \$330.63 = \$810.66 ÷ 50% (multiple procedure discount) = \$405.33
26410	0053	T	\$1,228.33	\$1,228.33 x 60% = \$737.00	\$737.00 x 0.9679 = \$713.34	\$1,228.33 x 40% = \$491.33	\$713.34 + \$491.33 = \$1,204.67 ÷ (multiple procedure discount) = \$602.34
26765	0062	T	\$2,042.65	\$2,042.65 x 60% =	\$1,225.59 x 0.9679 =	\$2,042.65 x 40% =	\$1,186.25 + \$817.06 = \$2,003.31

				\$1,225.59	\$1,186.25	\$817.06	
90471	0437	S	\$53.54	\$53.54 x 60% = \$32.12	\$32.12 x 0.9679 = \$31.09	\$53.54 x 40% = \$21.42	\$31.09 + 21.42 = \$52.51
99285	0616	Q3	\$492.69	\$492.69 x 60% = \$295.61	\$295.61 x 0.9679 = \$286.12	\$492.69 x 40% = \$197.08	\$286.12 + 197.08=\$483.20

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 73130 has status indicator Q1 ; 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.
- Procedure code 73140 has status indicator Q1; 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.
- Procedure code 26765, date of service March 17, 2015, 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 \$2,003.31. This amount multiplied by 200% yields a MAR of \$4,006.62.
- Procedure code 26410, date of service March 17, 2015, 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 \$602.34. This amount multiplied by 200% yields a MAR of \$1,204.68.
- Procedure code 11012, date of service March 17, 2015, 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 \$405.33. This amount multiplied by 200% yields a MAR of \$810.66.
- Procedure code 29125 has status indicator Q1; 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.
- Procedure code 99285 has status indicator Q3 denoting 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. This line is assigned status indicator V denoting a clinic or emergency department visit paid under OPPS with separate APC payment. The total Medicare facility

specific reimbursement amount for this line is \$483.20. This amount multiplied by 200% yields a MAR of \$966.40.

- Procedure code 90471 has status indicator S. The total Medicare facility specific reimbursement amount for this line is \$52.51. This amount multiplied by 200% yields a MAR of \$105.02.

Conclusion

The total allowable reimbursement for the services in dispute is \$7,093.38. This amount less the amount previously paid by the insurance carrier of \$7,093.67 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

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

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.