



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

St Davids Georgetown

Respondent Name

Standard Fire Insurance Co

MFDR Tracking Number

M4-16-2918-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

May 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our belief that we have submitted satisfactory proof that this claim was billed to the health care carrier within 95 days from July 2, 2015 and that it was submitted to the Workers' Compensation Carrier within 95 days from the date that it was learned that it should be billed to Workers' Compensation and should be adjusted for payment."

Amount in Dispute: \$27,115.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider has submitted appropriate documentation of an exception to the 95-day submission requirement being met, therefore substantiating timely submission for reimbursement. Reimbursement is being issued in accordance with the Division-adopted fee schedule."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 2, 2015, Outpatient Hospital Services, \$27,115.00, \$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 services provided in an

outpatient hospital setting.

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.
  - W3 – Additional payment made on appeal/reconsideration
  - P12 – Workers’ compensation jurisdictional fee schedule adjustment.

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which 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 applicable Medicare payment policy may be found at [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS).

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPSS services which are:

1. **How Payment Rates Are Set**, found at [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243664.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243664.html)  
*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.*
2. **Payment status indicator** - 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. The relevant status indicator may be found at the following: [www.cms.gov](http://www.cms.gov), Hospital Outpatient Prospective Payment – Final Rule, OPSS Addenda, Addendum D1.
3. **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. The relevant payment amount for each APC may be found at: [www.cms.gov](http://www.cms.gov), Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

### Issues

1. What is the applicable rule that pertains to reimbursement?
2. Are the insurance carrier’s reasons for denial or reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

### Findings

1. 28 Texas Administrative Code §134.403 (f) and (g) states in pertinent parts,

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. 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.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the submitted medical claim finds no request for separate reimbursement for implantables was made no was a billing certification found within submitted documentation. Therefore, the services in dispute will be calculated as follows:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
21462	T	0256	\$3,730.03	\$3,730.03 x 60% = \$2,238.02	\$2,238.02 x 0.9384 = \$2,100.16	\$3,730.03 x 40% = \$1,492.01	\$2,100.16 + \$1,492.01 = \$3,592.07	\$3,592.07 x 200% = \$7,184.14
							Total	\$7,184.14

2. The insurance carrier denied disputed services with claim adjustment reason code 97 – “Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” 28 Texas Administrative Code §134.403 (d) which 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...”

Review of the status indicator of the following disputed services finds:

- Procedure code C1713 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 85027 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J0330 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 J1094 has status indicator N denoting packaged items and services with no separate APC payment.
  - 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 J2710 has status indicator N denoting packaged items and services with no separate APC payment.
  - Procedure code Q9977 has status indicator N denoting packaged items and services with no separate APC payment
  - Procedure code 93005 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. Review of the submitted medical claim finds code 21462 with a status indicator T. Therefore no additional payment is due.
3. The total allowable reimbursement for the eligible service in dispute is \$7,184.14. The carrier paid \$7,184.34. No additional reimbursement is due.

**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	July , 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.**