



# 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**

Texas Orthopedic Hospital

**Respondent Name**

Travelers Casualty & Surety Co

**MFDR Tracking Number**

M4-16-3025-01

**Carrier's Austin Representative**

Box Number 5

**MFDR Date Received**

June 3, 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:** \$2,481.31

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier has reviewed the documentation and determined that the Provider has been appropriately reimbursed the Outpatient Hospital Fee Schedule. The Carrier believes no additional reimbursement is due."

**Response Submitted by:** Travelers

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2016 through February 1, 2016	Outpatient Hospital Services	\$2,481.31	\$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 performed in an outpatient hospital setting.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. 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
  - P12 – Workers’ Compensation Jurisdictional fee schedule adjustment
  - 799 – Allowance has been adjusted in accordance with OPPS multiple procedure rule
  - 193 – Original payment decision is being maintained. This claim was processed properly the first time

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 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>.

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 OPPS services which are:

1. **How Payment Rates are Set** - found at [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf), *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 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. The relevant status indicator may be found at the following: [www.cms.gov](http://www.cms.gov), Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
3. **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. 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.
4. **Discounting** - Multiple surgical procedures furnished during the same operative session are discounted. The full amount is paid for the surgical procedure with the highest weight. Fifty percent is paid for any other surgical procedure(s) performed at the same time;

### Issues

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

### Findings

1. 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.”

Review of the submitted medical claim finds the following OPPS Medicare payment policy per submitted code(s):

- Procedure code J1170 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 J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2704 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code C1713 has status indicator N denoting packaged items and services with no separate APC payment.
- Per Medicare National Correct Coding Initiatives Edits (CCI) found at [www.cms.gov](http://www.cms.gov), procedure code 29895 may not be reported with procedure code 29898 billed on the same claim. Payment for this service is included in the payment for the primary procedure.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005 has status indicator Q1 denoting STVX-packaged code; payment for this services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. Review of the submitted medical claim finds code 29898 had a status indicator of "T" therefore no payment can be recommended.

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..." Pursuant to provisions of Rule 134.403, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended for these services in dispute.

2. Based on the Status Indicator of the remaining services in dispute, the MAR is calculated per 28 Texas Administrative Code 134.403 (f) which states,

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;

Based on the APC of the remaining services in dispute, the MAR is calculated below:

Submitted code	Status Indicator	Multiple Procedure Discounting	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
27680	T	Yes paid at 100%	5122	\$2,395.59	\$2,395.59 x 60% = \$1,437.35	\$1,437.35 x 0.9615 = \$1,382.01	\$2,395.59 x 40% = \$958.24	\$1,382.01 + \$958.24 = \$2,340.25	\$2,340.25 x 200% = \$4,680.50

29898	T	Yes paid at 50%	5122	\$2,395.59 ÷ 50% = \$1,197.80	\$1,197.80 x 60% = \$718.68	\$718.68 x 0.9615 = \$691.01	\$1,197.80 x 40% = \$479.12	\$691.01 + \$479.12 = \$1,170.13	\$1,170.13 x 200% = \$2,340.26
27696	T	Yes paid at 50%	5122	\$2,395.59 ÷ 50% = \$1,197.80	\$1,197.80 x 60% = \$718.68	\$718.68 x 0.9615 = \$691.01	\$1,197.80 x 40% = \$479.12	\$691.01 + \$479.12 = \$1,170.13	\$1,170.13 x 200% = \$2,340.26
								Total	\$9,482.95

- Procedure code 97001 has status indicator A denoting services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c)(1) which states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The MAR is calculated as follows:

(DWC Conversion Factor / Medicare Conversion Factor) x allowable or 56.82/35.8043 x \$76.83 = **\$121.93.**

3. Pursuant to applicable rules and fee guidelines the total maximum allowable reimbursement for the services in dispute is \$9,482.95. No additional payment 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 20, 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.**