



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

Baylor Medical Center at Trophy Club

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-16-3105-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$14,288.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual denied payment of these two codes when there is no documented usage beyond allograft bone and bone marrow aspirate in the surgeon's operative report. The requestor billed \$4,495.00 for code E0749, a bone growth stimulator. Rule 134.600 indicates preauthorization is required for durable medical equipment in excess of \$500.00. Texas Mutual has no record of a preauthorization request for the stimulator from any party. No additional payment is due for code 38220. The adjusted APC rate is \$802.38 multiplied by 2.0 is \$1,604.76. The multiple procedure rule applies to this code, which drops the payment back to \$802.38."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5 – 7, 2015	Outpatient Hospital Services	\$14,288.90	\$9,240.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an

outpatient hospital setting.

3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization of Health Care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 225 – The submitted documentation does not support the service being billed
 - 615 – Payment for this service has been reduced according to the Medicare multiple surgery guidelines
 - P12 – Workers' compensation jurisdictional fee schedule adjustment
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - 197 – Precertification/authorization/notification absent
 - 768 – Reimbursed per O/P at 130%. Separate reimbursement for implantables (including certification) was requested per Rule 134.403(G).

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.

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
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, 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, 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;
5. **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. Was pre-authorization required?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier reduced the payment for the submitted code 38220 as 615 – "Payment for this service has been reduced according to the Medicare Multiple Surgery Guidelines." 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..."

Review of MLN (Medicare Learning Network) Matters MM9014, found at, www.cms.hhs.gov states, *Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:*

- *Major OPPS procedure codes (status indicators P, S, T, V);*
- *Lower ranked comprehensive procedure codes (status indicator J1);*

Review of the submitted medical claim finds the health care provider submitted code 22612 which has a Status Indicator of "J1." The code in dispute (38220) has a status indicator of "T." Pursuant to the above referenced Medicare Payment Policy the "T" status indicator code is packaged into the code paid by the carrier or 22612. No additional payment is recommended.

2. The insurance carrier denied the services in dispute (C1713, C1760) with claim adjustment reason code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication and 225 – "The submitted documentation does not support the service being bill. We will re-evaluate this upon receipt of the clarifying information." The carrier states in their position statement, "Texas Mutual denied payment of these two codes when there is no documented usage beyond allograft bone and bone marrow aspirate in the surgeon's operative report."

Review of the narrative description of Code C1713 is – "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)" and C1760 is – "Closure device, vascular (implantable/insertable)."

Review of the "Operative Report" from the health care provider finds, "We decorticated the facet joints transverse process and using allograft bone after it was soaked in bone marrow aspiration" and "We then laid new bone graft to bridge the transverse process facet joint ..."

Review of the Operative Report and the Respondent's statement support the use of the Code C1713. This code will be reimbursed per applicable Rules and Fee Guidelines.

28 Texas Administrative Code §134.403 (g) states in pertinent part,

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..

Review of the submitted documentation finds;

- "Strip canc 26 x 18 x 7 M " as identified in the itemized statement and labeled on the invoice as "Osteo Strip" with a cost per unit of \$8,400.00.
- The total net invoice amount (exclusive of rebates and discounts) is \$8,400.00. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$840.00. The total recommended reimbursement amount for the implantable item is \$9,240.00.

The Division finds support of payment of the code C1713, however no convincing evidence found to support the payment of code C1760.

- 3. The carrier denied code E0749 as 197 – “Precertification/authorization/notification absent.” 28 Texas Administrative Code 134.600 (p)(9) states in pertinent part,

Non-emergency health care requiring preauthorization includes:

- (9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental);

The submitted amount for the code in dispute is \$4,495.00 which is in excess of \$500 billed charges. The carrier’s denial is supported. No additional payment is recommended.

- 4. The total allowable for the services in dispute is \$9,240.00. The carrier previously paid \$0.00. The amount due to the requestor is \$9,240.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$9,240.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$9,240.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July , 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.