



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 Surgical Hospital Irving

Respondent Name

Markel Insurance Co

MFDR Tracking Number

M4-16-3280-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

June 27, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim is currently underpaid by \$5,735.54 per the allowance of \$11,860.87."

Amount in Dispute: \$5,735.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With regard to the implant charges, Requestor billed for several items that are not considered implants; a drill bit, countersink, BMA kit, and guide pin. These items are considered supplies and are not separately reimbursed as implants. Further, Requestor billed for two Fuseforce implant kits, when the documentation shows only one was used. In conclusion, no additional reimbursement is owed to Requestor for the date of service 11/24/15."

Response Submitted by: Downs ♦ Stanford 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 24, 2015, C1713, C9359, 20680-RT, 38220-RT, \$5,735.55, \$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

outpatient hospital services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 850-300 – Reviewed based on guidelines set forth per the applicable state workers' compensation fee schedule
  - 854 -009 – Implants reimbursable separately at cost plus appropriate mark-up. Cost determined by professional review
  - 855 – reimbursement for this procedure has been calculated according to the multiple/bilateral procedure rule
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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/Downloads/HospitalOutpaysfctsh.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysfctsh.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 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.
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. What is the applicable rule pertaining to reimbursement?
2. Were the implantables reimbursed per the applicable rules and fee guidelines?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. 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 (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.

Review of the submitted medical claim finds separate reimbursement for implantables was requested. Therefore, the services in dispute are reimbursed based on the following:

Submitted code	Status Indicator	Multiple Procedure Discount	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
20680	Q2	No	0022	N/A see below**					
28730	T	Yes, paid at 100%	0056	\$5,219.15	\$5,219.15 X 60% = \$3,131.49	\$3,131.49 X 0.9512 = \$2,978.67	\$5,219.15 x 40% = \$2,087.66	\$2,978.67 + \$2,087.66 = \$5,066.33	\$5,066.33 x 130% = \$6,586.23
38220	T	Yes, paid at 50%	0020	\$826.58 ÷ 50% = \$413.29	\$413.29 x 60% = \$247.97	\$247.97 X 0.9512 = \$235.87	\$413.29 x 40% = \$165.32	\$235.87 + \$165.32 = \$401.17	\$401.17 x 130% = \$521.52
								Total	\$7,107.75

\*\*Medicare Claims Processing Manual, found at; [www.cms.hhs.gov](http://www.cms.hhs.gov), Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section, 10.4 – Packaging, C. Packaging Types under the OPPS, states in pertinent part,

*T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported with the same date of service on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same date of service as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is made for the T-packaged service. T-packaged services are assigned status indicator Q2.*

Pursuant to the above no payment is due for code 20680.

2. The requestor states in their reconsideration request, “Rev code 278 (Implants) reimburses at 10% plus cost.” 28 Texas Administrative Code 134.403 (b)(2) states,

Implantable" means an object or device that is surgically:

- (A) implanted,
- (B) embedded,
- (C) inserted,
- (D) or otherwise applied, and
- (E) related equipment necessary to operate, program and recharge the implantable.

The items that meet this definition and were supported by the reviewed, “Operative Report” are;

- "Guide pin Kirschner wire" as identified in the itemized statement and labeled on the invoice as "K-wire" with a cost per unit of \$19.00;
- "Screw dart-fire 4.0 x 24" as identified in the itemized statement and labeled on the invoice as "cann screw" with a cost per unit of \$206.00;
- "Screw 20 20mm fuse for" as identified in the itemized statement and labeled on the invoice as "Fuseforce implant kit 20 x 20" with a cost per unit of \$1,796.00;
- "Putty 10cc" as identified in the itemized statement and labeled on the invoice as "putty 10cc" with a cost per unit of \$2,300.00.

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.

The total net invoice amount (exclusive of rebates and discounts) is \$4,321.00. 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 \$432.10. The total recommended reimbursement amount for the eligible implantable items is \$4,753.10.

3. The maximum allowable reimbursement for the eligible service is \$11,860.85. The carrier previously paid \$11,860.87. 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 , 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.**