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

Rio Grande Regional Hospital

Respondent Name

California Insurance Company

MFDR Tracking Number

M4-16-3306-01

Carrier's Austin Representative

Box Number 06

MFDR Date Received

June 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In closing, is it 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: $1,918.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent properly calculated reimbursement in this case and stands by the reasons for reduction of payment set forth in the Explanation of Benefits previously filed."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2015	Outpatient Hospital Services	$1,918.82	$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:
   - 222 – Charge exceeds Fee Schedule allowance
   - 351 – Service is included in the value of another surgical procedure

- 411 – National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day
- ANSI – 236 This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the national Correct Coding initiative
- ANSI197 – Payment is included in the allowance for another service/procedure
- ANSIP12 – 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.

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/HospitalOutpaysysfctsht.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, 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, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Issues

1. What is the applicable fee pertaining 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) 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;

The services in dispute are reimbursed based on the following:

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 or 0.8197	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
29881	T	0041	$2,151.57	$2,151.57 x 60% = $1,290.94	$1,290.94 x 0.8197 = $1,058.18	$2,151.57 x 40% = $860.63	$1,058.18 + $860.63 = $1,918.81	$1,918.81 x 200% = $3,837.62
							Total	$3,837.62

2. The remaining codes in dispute were reduced/denied with adjustment/reason code(s) ANSI197 – "Payment is included in the allowance for another service/procedure" and ANSI236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. 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 the payment policy finds the following:

- Procedure code J0670 has status indicator N denoting packaged items and services with no separate APC payment.

- Procedure code J1200 has status indicator N denoting packaged items and services with no separate APC payment.

- Procedure code J2001 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.

- Per Medicare Correct Coding Initiatives, procedure code 29875 may not be reported with procedure code 29881 billed on the same claim. Payment for this service is included in the payment for the primary procedure.

- Procedure code J0171 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 J1890 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 J2270 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 J3010 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J7120 has status indicator N denoting packaged items and services with no separate APC payment.

Pursuant to Rule 134.403 (d) the Carrier's reduction and denial is supported.

3. The maximum allowable reimbursement for the eligible service is $3,837.62. The carrier paid $3,837.62. 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	_Peggy Miller_ Medical Fee Dispute Resolution Officer	_July 29, 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.