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
MEMORIAL HERMANN SPECIALTY HOSPITAL

Respondent Name
LIVINGSTON INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-16-3344-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
July 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "implants shall be reimbursed at the lesser of manufacturer invoice amount plus add-on of 10% of $1,000 per billed item, whichever is less, but not to exceed $2000 per admission."

Amount in Dispute: $3,491.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The 'information which is needed for adjudication' which was lacking from Provider's bill was the Certification that Amount Billed Represents Actual Costs (Certification), which is required by Rule 134.403(g)(1) in order for costs to be reimbursed in accordance with the reimbursement methodology listed in rule 134.403(f)(1)(B). Without the Certification, reimbursement was not permitted per Rule 134.403(f)(1)(B); therefore, Respondent calculated reimbursement in accordance with the methodology provided in Rule 134.403(f)(1)(A)."

Response Submitted by: White Espy, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 29, 2015 to August 5, 2015	Outpatient Hospital Services with Implantable Items	$3,491.98	$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 acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
   - 59 – Processed based on multiple or concurrent procedure rules.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 16 – Claim/service lacks information which is needed for adjudication.
   - PN – The service is incidental with payment packaged or bundled into another service or APC payment.
   - 28 – The reduction was made for reasons indicated in note below or on the attached note or letter.
   - OL – Payment has been determined using the Clinical Laboratory Fee Schedule.

Issues

1. Are the insurance carrier's reasons for reduction or denial of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied or reduced payment for disputed services with claim adjustment reason codes 16 – "Claim/service lacks information which is needed for adjudication"; and 28 – "The reduction was made for reasons indicated in note below or on the attached note or letter."

   The respondent states that

   > The 'information which is needed for adjudication' which was lacking from Provider's bill was the Certification that Amount Billed Represents Actual Costs (Certification), which is required by Rule 134.403(g)(1) in order for costs to be reimbursed in accordance with reimbursement methodology listed in Rule 134.403(f)(1)(B). Without the Certification, reimbursement was not permitted per Rule 134.403(f)(1)(B); therefore, Respondent calculated reimbursement in accordance with the methodology provided in Rule 134.403(f)(1)(A).

   28 Texas Administrative Code §133.3(a) requires that:

   > Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as . . . "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.

   Review of the submitted explanations of benefits finds that the explanation "Claim/service lacks information which is needed for adjudication" was located next to ANSI Reason Code 16, in proximity to the denied charge for the implantable services. However, the explanation for additional remark code 28 — "The reduction was made for reasons indicated in note below or on the attached note or letter" was found at the bottom of page 3 of the EOB — without any obvious connection to services or reduction codes it was intended as a further clarification of.

   Furthermore, the "note below" (of which there are several) that remark code 28 is referring to, is also not discernible from the submitted information.

   There is a further comment at the bottom of page 4 of the EOB that states:

   > IF REQUESTING REIMBURSEMENT FOR IMPLANTS PLEASE REFER TO TDI RULE 134.
   >
   > 403 FOR PROPER SUBMISSION OF THE BILL.

The line break in the middle of the EOB comment following the period at the end of “TDI RULE 134.” renders the sentence confusing — as if referring to the entirety of Chapter 134 — while making the second line appear to be a different description regarding a (non-existent) remark code “403.”

Moreover, nowhere in the submitted materials (that were communicated by the insurance carrier to the health care provider prior to the filing of the request for MFDR) did the insurance carrier describe the missing document or the information that was needed for adjudication. There was no obvious way for the health care provider to discern what information was lacking. The Division therefore finds that the insurance carrier’s communication was not of sufficient, specific detail to allow the responder (the health care provider) to easily identify the information required to resolve the issue or question related to the medical bill. For this reason, the insurance carrier’s payment reduction reasons are not supported.

28 Texas Administrative Code §133.307(d)(2)(F) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.”

Insofar as the missing certification was not communicated to the requestor prior to the filing of the request for MFDR, it is a new denial reason or defense that the respondent has waived, and which may not be raised or considered in this review.

However, the implantables must still be certified in order to be eligible for reimbursement under the provision for separate reimbursement found in 28 Texas Administrative Code §134.403(f)(1)(B) when a facility requests such reimbursement in accordance with subsection (g).

Subsection (g)(1) requires that a facility billing separately for implantables shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) including the sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Note that subsection (g)(2) provides that a carrier may use the audit process under 28 Texas Administrative Code §133.230 (relating to Insurance Carrier Audit of a Medical Bill) to seek verification of the amount certified. The rule further specifies that such verification may also take place in the Medical Dispute Resolution process under Rule §133.307.

Review of the submitted information finds that the requestor has requested separate reimbursement for implantables and has included with the submitted billing a certification meeting the requirements of subsection (g)(1). Accordingly, the disputed services will be reviewed for reimbursement in accordance with the payment provisions for separate reimbursement of implantables under Rule §134.403(f)(1)(B).

2. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(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 §134.403(g). The facility’s total billed charges for the separately reimbursed implantable items are $7,803.20. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

   - Procedure code C1713 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 C1762 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 85014, date of service July 29, 2015, has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services.
   - Procedure code 85018, date of service July 29, 2015, has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services.
   - Procedure code 73560 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 is separately payable only if no other such procedures are reported.
   - Procedure code 29881 has status indicator T denoting a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,151.57. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,290.94. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $1,249.50. The non-labor related portion is 40% of the APC rate or $860.63. The sum of the labor and non-labor related amounts is $2,110.13. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,055.07. This amount multiplied by 130% yields a MAR of $1,371.59.
   - Procedure code 29888 has status indicator T denoting significant procedures subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0052, which, per OPPS Addendum A, has a payment rate of $6,322.79. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,793.67. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $3,671.89. The non-labor related portion is 40% of the APC rate or $2,529.12. The sum of the labor and non-labor related amounts is $6,201.01. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,775, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.185. This ratio multiplied by the billed charge of $15,003.00 yields a cost of $2,775.56. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $6,201.01 divided by the sum of all APC payments is 85.46%. The sum of all packaged costs is $1,226.70. The allocated portion of packaged costs is $1,048.33. This amount added to the service cost yields a total cost of $3,823.89. The cost of these services exceeds the annual fixed-dollar threshold of $2,775. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $6,201.01. This amount multiplied by 130% yields a MAR of $8,061.31.
   - Procedure code J0690 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 J1100 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 J1885 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 J2001 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 J2175 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 J2270 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 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 J2550 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 J2795 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.

4. Additionally, the provider requested separate reimbursement of implantables.

   Per §134.403(b)(2), "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.

   Per §134.403(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."

   Review of the submitted documentation finds the following implantables listed in the itemized statement:

   - "KIT CROSS PIN SOFT TISSU" as identified in the itemized statement; however, based on review of the submitted invoices, operative report and implant record, the records presented to MFDR did not support this item. Accordingly, additional reimbursement is not recommended for this item.
   - "KIT INTRAFIX" as identified in the itemized statement; however, based on review of the submitted invoices, operative report and implant record, the records presented to MFDR did not support this item. Accordingly, additional reimbursement is not recommended for this item.

   Four listed implantables were supported based on the Implant Record, Operative Report, and invoices:

   - 1 "SHEATH TIBL 30MM X 10.7M" as identified in the itemized statement and labeled on the invoice as "BIO-INTRAFIX TIBIAL SHEATH, LARGE" with a cost per unit of $328.00;
   - 1 "SYSTEM PIN 3.3MM CROSS S" as identified in the itemized statement and labeled on the invoice as "RIGIDIFIX BIOCRYL FEMORAL ST CROSS PIN KIT" with a cost per unit of $498.00. While not specified in the submitted materials, information from the manufacturer's website states that the RIGIDFIX BIOCRYL Femoral 3.3mm ST Cross Pin Kit includes: two (2) absorbable Cross Pins, two (2) disposable sleeve assemblies, and one (1) interlocking trocar—which is congruous with the number of pins actually implanted per the Operative Report. Note that the invoice indicates two kits were ordered, but only one kit was used or implanted according to the implant record. Therefore, reimbursement is recommended for only one kit.
   - 1 "SCREW BONE 30MM X 7MM TO" as identified in the itemized statement and labeled on the invoice as "BIO-INTRAFIX TAPERED SCREW 7-9mm X 30mm" with a cost per unit of $309.00;
   - 1 "ALLOGRAFT TIBIALIS ANT" as identified in the itemized statement and labeled on the invoice as "Anterior Tissue (.8 x 21.5)" with a cost per unit of $2,695.00.

   The total net invoice amount (exclusive of rebates and discounts) is $3,830.00. 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 $383.00. The total recommended reimbursement amount for the implantable items is $4,213.00.

5. The total allowable reimbursement for the services in dispute, including the separate reimbursement requested for the implantable items, is $13,645.90. This amount less the amount previously paid by the insurance carrier of $14,512.16 leaves an amount due to the requestor of $0.00. Additional reimbursement is not recommended.

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 on 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

	Grayson Richardson	August 12, 2016
Signature	Medical Fee Dispute Resolution Officer	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, effective May 31, 2012, *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.