



# 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**

Texas Health of Plano

**Respondent Name**

Standard Fire Insurance Co

**MFDR Tracking Number**

M4-16-3444-01

**Carrier's Austin Representative**

Box Number 05

**MFDR Date Received**

July 14, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please submit this claim for the correct allowable per ASC Rule 134:402: Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

**Amount in Dispute:** \$392.65

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2015	Outpatient Hospital Services	\$392.65	\$165.94

#### 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 outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed

- 802 – Charge for this procedure exceeds the OPSS schedule allowance
- 6549 – Fair-Pay-R05-Re-reviewed at Provider’s request with additional information and documentation – No additional allowance has been recommended.

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/HospitalOutpaysysfctst.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctst.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;
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 fee pertaining to reimbursement?
2. 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;

Submitted code	Status Indicator	Composite criteria met?	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index/0.9512	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
72125	Q3	no	332	\$120.02	$\$120.02 \times 60\% = \$72.01$	$\$72.01 \times 0.9512 = \$68.50$	$\$120.02 \times 40\% = \$48.01$	$\$68.50 + \$48.01 = \$116.51$	$\$116.51 \times 200\% = \$233.02$
96375	S		436	\$32.58	$\$32.58 \times 60\% = \$19.55$	$\$19.55 \times 0.9512 = \$18.60$	$\$32.58 \times 40\% = \$13.03$	$\$18.60 + \$13.03 = \$31.63$	$\$31.63 \times 200\% = \$63.26$
99284	Q3	no	615	\$333.80	$\$333.80 \times 60\% = \$200.28$	$\$200.28 \times 0.9512 = \$190.51$	$\$333.80 \times 40\% = \$133.52$	$\$190.51 + \$133.52 = \$324.03$	$\$324.03 \times 200\% = \$648.06$
								Total	\$944.34

The remaining services were reviewed as follows:

- Procedure code 71101 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 may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 72040 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 may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 73000 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 may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 73080 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 may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 73090 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 may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 73130 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 may be separately payable only if no other such procedures are reported for the same date.
- Procedure code 73562 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 may be separately payable only if no other such procedures are reported for the same date.

- Procedure code 73630 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 may be separately payable only if no other such procedures are reported for the same date.
- Review of the CMS National Correct Coding Edits finds procedure code 96374 may not be reported with procedure code 99284 billed on the same claim. 28 Texas Administrative Code §134.203 (b) states in pertinent part,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

- 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.
2. The maximum allowable reimbursement for the eligible service is \$944.34. The carrier paid \$778.40. The remaining balance is \$165.94. This amount is 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 \$165.94.

***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 \$165.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order

**Authorized Signature**

		August , 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, 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.**