TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Donna ISD

MFDR Tracking Number
M4-17-2550-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
April 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $248.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the above, CPT code 29881 was underpaid $10.64, CPT code 93005 was overpaid $98.38 and no reimbursement would be due on CPT codes 96374 and 96375, due to lack of modifiers. It is our position that no further reimbursement would be due the provider."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 13 – 20, 2016	29881, 93005, 96375, 96374	$248.40	$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

- 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 outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
    - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
    - 236 – This procedure or procedure/modifier combination is not compatible with another procedure

or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 350 – Bill has been identified as a request for reconsideration or appeal
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. What is the Medicare payment rule?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $248.40 for outpatient hospital services with date of service December 13 - 20, 2016.
   The carrier reduced the payment amount as P12 – "Workers' Compensation Jurisdictional Fee Schedule Adjustment." The requestor states in pertinent part, "…there is a pending payment in the amount of $248.40." The Respondent states in pertinent part, "It is our position that no further reimbursement would be due the provider." Therefore, the service in dispute will be reviewed per applicable Rules and Fee Guidelines discussed below.

The relevant portions of 28 Texas Administrative Code 134.403 are:

> (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise
>
> > (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
>
> (d) 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 with any additions or exceptions specified in this section, including the following paragraphs.
>
> (f) 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; 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

Review of the submitted medical claim finds implants were not requested. The maximum allowable reimbursement for the services in dispute listed on DWC 60 is calculated is found below.

The facility specific reimbursement amount is calculated as follows:

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider 0.8026	40% non-labor related	Payment rate x 200% =
29881	T	5122	$2,395.59	$2,395.59 x 60% = $1,437.35	$1,437.35 x 0.8026 = $1,153.62	$2,395.59 x 40% = $958.24	$1,153.62 + $958.24 = $2,111.86 x 200% = $4,223.72
93005	Q1	5733	N/A *see below				
96374	S	5693	N/A *see below				
96375	S	5692	N/A *see below				
						Total	$4,223.72

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APCS as follows:

- **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.*

  - **10.1.1 - Payment Status Indicators**

    An OPPS payment status indicator is assigned to every HCPCS code. 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. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

    The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

- **10.2 - 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. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

- **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.

Review of the applicable Medicare Payment Policy finds the following regarding codes 93005, 96374 and 96374:

- Procedure code 93005, billed December 13, 2016, has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed. As shown above Procedure code 29881 has a status indication of "T" therefore separate payment is not allowed.
- Per CCI edits, procedure code 96375 has a conflict with procedure code 29881 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.
- Per CCI edits, procedure code 96374 has a conflict with procedure code 29881 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.

3. The total recommended reimbursement for the disputed services is $4,223.72. The insurance carrier has paid $4,311.46 leaving an amount due to the requestor of $0.00. Additional payment 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 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

		May 19, 2017
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.