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 SW Fort Worth

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-17-2795-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
May 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We show this should be processed for the additional allowance due as HCPC 29824 is not bundled into the HCPC 29828."

Amount in Dispute: $2,344.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review, Wellcomp stands on its original recommendation of reimbursement $9,683.30 therefore no additional is recommended."

Response Submitted By: Wellcomp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19, 2016	29824	$2,344.07	$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:
  - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
  - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. What is the applicable rule that pertains to reimbursement?

Findings

1. The requestor is seeking $2,344.07 for outpatient hospital services with date of service May 19, 2016. The carrier reduced the payment amount as 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

The Rule specific to outpatient hospital services is found in 28 Texas Administrative Code 134.403. The relevant portions 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

The Medicare Claims processing Manual defines the terms, Status Indicators and APC Payment Groups 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).

Review of the submitted medical claim finds the submitted procedure code 29828 – "Arthroscopy, shoulder, surgical; biceps tenodesis."

Review of the Addendum B – "Final OPPS payment by HCPCS Code" found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html, for this date of service shows this code to have a "J1" status indicator which is defined as;

J1 – "Hospital Part B services paid through a comprehensive APC. Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim…"

The Medicare Payment Policy regarding Comprehensive APCS shown below has a direct impact on the code in dispute of 29824 – "Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)" and will be discussed below.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf 10.2.3 - Comprehensive APCs

Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of HCPCS codes designated with status indicator J1.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- *major OPPS procedure codes (status indicators P, S, T, V)*
- *lower ranked comprehensive procedure codes (status indicator J1)*
- *non-pass-through drugs and biologicals (status indicator K)*

- *blood products (status indicator R)*
- *DME (status indicator Y)*
- *therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)*

The status indicator shown at Addendum B for the service in dispute is:

- 29824 - Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure) has a status indicator of "T." As shown above this is packaged and no separate reimbursement is made.

The carrier's denial is supported. 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 23, 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.