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
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-17-3162-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 26, 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: $4,733.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent stands by the original payment for the service in dispute. Requestor was reimbursed pursuant to the Medicare fee guidelines for the total outpatient procedure. Some billed services are not paid separately. Therefore, no additional monies are owed for the date of service 11/10/16."

Response Submitted by: Downs • Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 10, 2016	Outpatient Hospital Services	$4,733.08	$31.36

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 outpatient hospital services
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment
- P12 – Workers compensation jurisdictional fee schedule adjustment
- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance
- 797 – Service not paid under Medicare OPPS
- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code (90000-99999) has been disallowed.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What Division Rule applies to reimbursement of outpatient hospital services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for $4,733.08 for outpatient hospital services rendered November 10, 2016.

   The insurance carrier reduced the disputed services with reduction codes, 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 4915 - The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment."

   These outpatient hospital services are 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 is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are:

   - **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.*

   - **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.

   - **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.

– **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**.

These payment policies are discussed below in the calculation of the maximum allowable reimbursement.

2. The Division rule pertaining to the calculation of fees for outpatient hospital services is found in 28 Texas Administrative Code §134.403 (f) which 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 reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2017 Wage Index Adjustment for provider 0.8026	40% non-labor related	Payment
29888	5124	J1	$7,064.07	$7,064.07 x 60% = $4,238.44	$4,238.44 x 0.8026 = $3,401.77	$7,064.07 x 40% = $2,825.63	$3,401.77 + $2,825.63 = $6,227.40 x 200% = $12,454.80
						Total	$12,454.80

The Medicare Claims Processing Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf states in pertinent part;

***10.2.3 - Comprehensive APCs**, (Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16)*

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 remaining codes in dispute have the following status indicators:

- Procedure code 29880 has a status indicator of "T." Per the above this service is packaged into primary procedure of code 29888.

- Procedure code 94640 has a status indicator of "S." Per the above this service is packaged into primary procedure of code 29888.

- Procedure code 96374 was denied by the carrier as 906 – "In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code (90000-99999) has been disallowed." Review of the 2016 NCCI edits, finds the carrier's denial is supported. No additional payment is due.

3. The total recommended reimbursement for the disputed services is $12,454.80. The insurance carrier has paid $12,423.44 leaving an amount due to the requestor of $31.36. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $31.36.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $31.36, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		July 26, 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 Rule §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. **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.