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 Institute for Surgery

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-18-3513-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We did not request separate reimbursement for implants therefore TX Uplift is 200%."

Amount in Dispute: $2,621.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The invoice submitted by the facility included the required certification statement, 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge,' as required by §134.403(g)(1), which indicated the provider was seeking reimbursement for implants."

Response Submitted by: Foresight

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 29, 2017	Outpatient Hospital Services	$2,621.60	$2,621.60

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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 881 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
   - 131 – Claim specific negotiated discount.
   - 18 – Duplicate claim/service
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 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.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CIQ378 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
- 222 – Charge exceeds fee schedule allowance.
- 240 – Charge reviewed to multiple procedure ground rules.
- W3 – W3

Issues

1. Did the health care provider request separate reimbursement for implantables?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient surgery with payment subject to the division's Outpatient Hospital fee guideline at 28 Texas Administrative Code §134.403.

   Rule §134.403(f)(1) provides that:

   > 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 respondent's position statement asserts:

   > Based on the documentation submitted, the provider was seeking separate reimbursement for implantables. The invoice submitted by the facility included the required certification statement, 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge,' as required by §134.403(g)(1), which indicated the provider was seeking reimbursement for implants.

   Review of the submitted billing information finds no request from the health care provider for separate reimbursement of implantables. Despite the invoice containing a signed certification as to the true and correct actual cost of the implanted items, the division finds no clear statement that the hospital chose to receive separate reimbursement for implanted items.

   Rule §133.10(f)(2)(QQ), regarding the division's required billing forms and formats, requires that "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."

   Review of the submitted UB-04 medical billing form finds that Remarks field 80 contains no indication that separate reimbursement of implants was requested. Neither was such a request found elsewhere on the bill.

   Furthermore, review of the provider's request for reconsideration letter finds the statement "We did not request separate reimbursement for implants, therefore TX uplift is 200%." This was not addressed or considered by the insurance carrier in their response to reconsideration or on their explanation of benefits.

   The adoption preamble to the Outpatient hospital fee guideline is clear that the choice to request separate reimbursement of implantables lies with the medical provider, not the insurance carrier. And the plain language of the rule makes it clear that, in the absence of such a request, the default payment should be the Medicare facility specific reimbursement (including outlier payments) multiplied by 200%.

   Based on the preponderance of evidence, the division finds that the health care provider's position is supported, whereas the insurance carrier has failed to support their position. Consequently, the division will review the disputed services for payment at the 200% rate (inclusive of implantable items) pursuant to Rule §134.403(f)(1)(A).

2. Per 28 Texas Administrative Code §134.403, the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set out in the rules.

Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the outpatient services in dispute. As found above, the provider did not choose separate payment of implants.

Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 27766 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except for limited exclusions that do not apply to this claim). This code is assigned APC 5114. The OPPS Addendum A rate is $5,221.57. This is multiplied by 60% for an unadjusted labor-related amount of $3,132.94, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $3,068.40. The non-labor related portion is 40% of the APC rate, or $2,088.63. The sum of the labor and non-labor portions is $5,157.03. The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0. The Medicare facility specific amount of $5,157.03 is multiplied by 200% for a MAR of $10,314.06.
- Payment for all other services on the claim is packaged with the primary comprehensive service in accordance with Medicare payment policy regarding comprehensive APCs. Reimbursement is included with payment for the primary J2 status procedure. Please see Medicare Claims Processing Manual Chapter 4 §10.2.3 for details.

3. The total recommended reimbursement for the disputed services is $10,314.06. The insurance carrier paid $7,647.50. The requestor is seeking additional reimbursement of $2,621.60. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 $2,621.60.

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 $2,621.60, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 8, 2018
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.