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
Doctors Hospital at Renaissance

Respondent Name
Texas Municipal Intergovernmental Risk Pool

MFDR Tracking Number
M4-18-4802-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 26356, allowed amount of $1186.75, multiplied at 130%, CPT Code 64890, allowed amount of $4152.23, multiplied at 130% plus $7,177.50 implants reimbursement should be $14,118.14. Payment received was only $9,298.03 thus, according to these calculations; there is a pending payment in the amount of $4,820.12."

Amount in Dispute: $8,827.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The purpose of the initial bill and the request for reconsideration and the request for medical fee dispute resolution being the same is to have a bill that goes through the appeals process that is consistent with the initial bill. Here that consistency is not met. The provider is not entitled to additional reimbursement."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 29, 2018	Outpatient Hospital Services	$8,827.50	$4,927.76

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:
   - P12 – Workers' compensation jurisdictional fee
   - 97 – Payment is included in the allowance
   - 472 – OPPS/APC payment is not allowed

Issues

1. Is the respondent's position statement supported?
2. What is the applicable rule(s) for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered on May 29, 2018. Specifically the implants provided at the time of surgery in the amount of $8,827.50

   The respondent states in part, "…The provider's initial medical bill did not request separate reimbursement of implants." However 28 Texas Administrative Code §134.403 (g) (1) and (2) state in pertinent parts,

   > A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."
   >
   > A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. **Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B) of this title.**

   Review of the submitted documentation found the required billing certification and invoice was included with the request for MFDR. Based on the above the review of the allowed amount will include separate reimbursement for the implants. The maximum allowable reimbursement is calculated below.

2. 28 Texas Administrative Code §134.403 (f) states,

   > 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.
   >
   > (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

   The calculations based on the above is found below.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

Reimbursement for the services as billed is calculated as follows:

- Procedure code A6222 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code C1763 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code 36415, billed May 25, 2018, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 80048, billed May 25, 2018, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85027, billed May 25, 2018, has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 26356, billed May 25, 2018, has a status indicator of J1. The Medicare Payment policy found at www.cms.gov, Claims Processing Manual, Chapter 4, Section 10.2.3 states in pertinent part,

  > *Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:*
  > *• lower ranked comprehensive procedure codes (status indicator J1)*

  The ranking of this Procedure Code is 1569. The ranking for the other J1 status indicator (Procedure Code 64890) is 614. As this is not the highest ranking code, separate payment is not recommended.
- Procedure code 64890, billed May 25, 2018, has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is assigned APC 5432. The OPPS Addendum A rate is $4,627.59, multiplied by 60% for an unadjusted labor amount of $2,776.55, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $2,301.48. The non-labor portion is 40% of the APC rate, or $1,851.04. The sum of the labor and non-labor portions is $4,152.52. The Medicare facility specific amount of $4,152.52 is multiplied by 130% for a MAR of $5,398.28.
- Procedure code J0690 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J3010 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2704 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2710 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2765 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2250 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

- Procedure code J1100 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J1885 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code A9270 has status indicator E1, for excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.

3. Per Rule §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds the following implants:

   - "Axoguard Nerve connector 3mm" as labeled on the invoice with a cost per unit of $1,675.00;
   - "1mm Diam, Avance Nerve Graft, 70" as labeled on the invoice with a cost per unit of $6,350.00.

   The total net invoice amount (exclusive of rebates and discounts) is $8,025.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $802.50. The total recommended reimbursement amount for the implantable items is $8,827.50.

4. The total recommended reimbursement for the disputed services is $14,225.78. The insurance carrier paid $9,298.02. The amount due is $4,927.76. 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 $4,927.76.

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 $4,927.76, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 2018 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.