



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

Ector County Hospital District

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-19-5172-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 9, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the TDI/DWC fee schedule this account qualifies for an outlier payment.."

Amount in Dispute: \$2,785.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The payment was properly adjusted pursuant to the applicable fee schedule and guidelines."

Response Submitted by: Zurich American Insurance Co

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 24, 2018, Outpatient hospital services, \$2,785.52, \$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

- 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 - 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 for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of \$2,785.52 for outpatient hospital services rendered on November 24, 2018 stating the claim qualifies for an outlier payment.

28 TAC §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 Medicare Claim Processing Manual, Chapter 4, Section 10.1 at www.cms.gov states,

The current outlier payment is determined by:

- Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass-through status to payment for the associated procedure, by multiplying the total charges for OPPS services by each hospital's overall CCR (see §10.11.8 of this chapter); and
- Determining whether the total cost for a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year; and
- If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPPS payment.

The total cost of all packaged items and services, including the cost of uncoded revenue code lines with a revenue code status indicator of "N", that appear on a claim is allocated across all separately paid OPPS services that appear on the same claim. The proportional amount of total packaged cost allocated to each separately paid OPPS service is based on the percent of the APC payment rate for that service out of the total APC payment for all separately paid OPPS services on the claim.

For this time period a **fixed-dollar threshold of \$4,825 combined with the multiple threshold of 1.75 times the APC payment rate** must be met for the service to qualify for an outlier payment.

The maximum allowable reimbursement per the above details if the service qualifies for an outlier payment is shown below:

- Procedure code 71045 has status indicator Q3, for conditionally packaged codes paid as a composite if OPPS criteria are met. As packaging criteria were not met, this line is separate. This code is assigned APC 5521. The OPPS Addendum A rate is \$62.12, multiplied by 60% for an unadjusted labor amount of \$37.27, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of \$33.43. The non-labor portion is 40% of the APC rate, or \$24.85. The sum of the labor and non-labor portions is \$58.28. The cost of

services is \$74.80 which does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$58.28 is multiplied by 200% for a MAR of \$116.56.

- Procedure code 72126 has status indicator Q3 and is assigned composite APC 8006. Calculated below.
- Procedure code 70450 has status indicator Q3 and is assigned composite APC 8006. Calculated below.
- Procedure code 71260 has status indicator Q3 and is assigned composite APC 8006. Calculated below.
- Procedure code 74177 has status indicator Q3 and is assigned composite APC 8006. Calculated below.
- Procedure code 96374 has status indicator S and is assigned APC 5693. The OPPS Addendum A rate is \$191.09, multiplied by 60% for an unadjusted labor amount of \$114.65, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of \$102.83. The non-labor portion is 40% of the APC rate, or \$76.44. The sum of the labor and non-labor portions is \$179.27. The cost of services \$57.35 which does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$179.27 is multiplied by 200% for a MAR of \$358.54.
- Procedure code 99284 has status indicator J2 when billed with more than eight hours of observation but when not a status indicator of V. This code is assigned APC 5024. The OPPS Addendum A rate is \$355.53, multiplied by 60% for an unadjusted labor amount of \$213.32, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of \$191.33. The non-labor portion is 40% of the APC rate, or \$142.21. The sum of the labor and non-labor portions is \$333.54. The cost of services is \$307.42 which does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$333.54 is multiplied by 200% for a MAR of \$667.08.
- Procedure code G0390 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5045. The OPPS Addendum A rate is \$957.57, multiplied by 60% for an unadjusted labor amount of \$574.54, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of \$515.30. The non-labor portion is 40% of the APC rate, or \$383.03. The sum of the labor and non-labor portions is \$898.33. The cost of services is \$1,634.18 which does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$898.33 is multiplied by 200% for a MAR of \$1,796.66.
- Procedure codes 72126, 70450, 71260, and 74177 have status indicator Q3, for packaged codes paid through a composite APC. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast and is assigned APC 8006. The OPPS Addendum A rate is \$500.85, multiplied by 60% for an unadjusted labor amount of \$300.51, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of \$269.53. The non-labor portion is 40% of the APC rate, or \$200.34. The sum of the labor and non-labor portions is \$469.87. The cost of services is \$2,799.00 which does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$469.87 is multiplied by 200% for a MAR of \$939.74.

2. The total recommended reimbursement for the disputed services is \$3,878.58. The insurance carrier paid \$3,910.59. Additional payment is not recommended.

Conclusion

For the reasons stated above, DWC 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, DWC hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 25, 2019

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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.