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
SOUTH TEXAS SPINE & SURGICAL HOSPITAL

Respondent Name
SOUTHWESTERN BELL TELEPHONE

MFDR Tracking Number
M4-19-5239-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 20, 2019

Response Submitted By
Foresight Implant Cost Containment

REQUESTOR'S POSITION SUMMARY

"Per the fee guidelines, the expected reimbursement is based on the 2019 Medicare CPT 63685 allowable of $25,268.19 at 130% for a total of $32,848.65 in addition to the cost of implants $18,353 plus 10% … for a total of $53,036.95…"

RESPONDENT'S POSITION SUMMARY

"Per the provider pricing indicated on the INVOICE, ForeSight recommended allowance for Revenue Code 0278 was $147.40 … L8688 recommended allowance for the PROCLAIM 7 Dual Octrode System kit at facility cost $18,219.00 plus $1,000… Total recommended allowance of $19,366.40."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 21, 2019	Outpatient Hospital Services	$25,008.11	$455.92

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.
   - 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.
   - OA – The amount adjusted is due to bundling or unbundling of services.
   - CO – The amount adjusted due to a contractual obligation between the provider and the payer. It is not the patient's responsibility under any circumstances.

- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical. Please expect a detailed explanation of review for surgical implant charges directly from ForeSight Medical and direct all surgical implant inquires to ForeSight Medical at 813-950-5346.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced payment for disputed services using group code CO – "The amount adjusted due to a contractual obligation between the provider and the payer. It is not the patient's responsibility under any circumstances."; and claim adjustment code 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT."

   Based on records maintained by DWC, the self-insured employer has not reported to DWC that the injured employee was enrolled in a certified workers' compensation health care network (HCN) established under Texas Insurance Code Chapter 1305. The response does not include any documentation to support that the injured employee is enrolled in a certified HCN.

   No information was presented by either party to support a contractual obligation between the provider and the payer, or that these services are subject to a contracted fee arrangement between the parties to this dispute. The above reduction reasons are not supported. The disputed services will therefore be reviewed for payment following the requirements of the Labor Code and DWC Rules.

2. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

   The provider requested separate payment for implants; therefore, 28 TAC §134.403(f)(1)(B), requires the Medicare facility specific amount (including outlier payments) be multiplied by 130 percent to determine the DWC fee.

   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 63685 is the primary procedure on the bill. This code has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5464. The OPPS Addendum A rate is $27,697.85, which is multiplied by 60% for an unadjusted labor amount of $16,618.71. This is multiplied by the facility wage index of 0.8538 for an adjusted labor amount of $14,189.05. The non-labor portion is 40% of the APC rate, or $11,079.14. The service costs do not meet the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $25,268.19. This is multiplied by 130% for a MAR of $32,848.65.
   - Payment for all other services on the bill is packaged with the primary comprehensive J1 service per Medicare policy regarding comprehensive APCs. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details.

   Additionally, the provider requested separate reimbursement of implantables. Per 28 TAC §134.403(g):

   > Implantables, when billed separately by the facility … 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:

- "Anchor Sleeve, MRC US" with an invoice cost per unit of $67.00 at 2 units, for a total cost of $134.00.
- "PROCLAIM 7 Dual Octrode System" with an invoice cost per unit of $18,219.00.

The total net invoice amount (exclusive of rebates and discounts) is $18,353.00. 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 $1,013.40. The total recommended reimbursement amount for the implantable items is $19,366.40.

The total recommended reimbursement for the disputed services and implanted items is $52,215.05.

The insurance carrier paid $28,028.84 during the bill review process. The carrier paid an additional $23,730.29 after the filing of this medical fee dispute. Supplemental response information supports carrier payment of the above amount by electronic funds transfer issued September 9, 2019. The total carrier payment is $51,759.13.

The total recommended reimbursement of $52,215.05, less the total insurance payments of $51,759.13, leaves a remaining balance due of $455.92. This amount is recommended.

Conclusion

For the reasons above, the requestor has established additional payment is due. The amount ordered is $455.92.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $455.92, plus accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 13, 2019
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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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