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
XL INSURANCE AMERICA, INC.

MFDR Tracking Number
M4-20-0285-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 30, 2019

Response Submitted By
Broadspire

REQUESTOR'S POSITION SUMMARY

"Despite our reconsideration request which included a copy of the authorization & revision of the approved DOS, the carrier has denied the claim."

RESPONDENT'S POSITION SUMMARY

"Payment has been made for $66,296.56. We are attaching the EOB."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 2, 2018	Outpatient Hospital Services	$74,922.27	$9,212.50

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) in Title 28, Part 2 of the Texas Administrative Code.

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:
   - D10 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES
   - 00438 – (197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT.
   - 00663 – (P12) REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES.
   - Z652 - Recommendation of payment has been based on a procedure code which best describes services rendered.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the recommended payment for the services in dispute?
3. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Upon initial consideration of the bill, the insurance carrier denied the disputed services with claim adjustment reason code 00438 – (197) Precertification/authorization/notification/Pre-treatment absent.

   The submitted documentation supports the services were preauthorized. This denial reason is no supported.

   After reconsideration, the insurance carrier did not maintain the denial reason related to preauthorization; however, despite the initial bill having been submitted timely to the carrier, the carrier denied the request for reconsideration with claim adjustment reason code D10 – "The time limit for filing has expired."

   The initial explanation of benefits indicates the medical bill was received less than one month following the date of service. This denial reason related to untimely filing is not supported.

   In response to the request for Medical Fee Dispute Resolution, the carrier reprocessed the bill, issuing payment of $66,296.56, without maintaining any denial reasons related to authorization or timeliness.

   Consequently, the division concludes there are no outstanding issues related to authorization or timeliness. The disputed services will therefore be reviewed for payment consistent with DWC rules and fee guidelines.

   Per Rule 28 TAC §133.307(d)(2)(F),"The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Accordingly, any newly raised denial reasons or defenses submitted after the filing of the MFDR request shall not be considered in this review.

2. This dispute regards outpatient surgery 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. Rule 28 TAC §134.403(f)(1)(B), requires the facility specific amount be multiplied by 130 percent. Per 28 TAC §134.403(f)(2), when calculating outlier payments, the facility's total billed charges are reduced by the billed charges for implants reimbursed separately under 28 TAC §134.403(g). The implant charges total $162,560.00. The total billed charges are therefore reduced by this amount when calculating any outlier payment. The adjusted cost of services did not exceed the threshold for outlier payment.

   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 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 $27,891.79. This is multiplied by 60% for an unadjusted labor amount of $16,735.07, and in turn multiplied by facility wage index 0.8538 for an adjusted labor amount of $14,288.40. The non-labor portion is 40% of the APC rate, or $11,156.72. The sum of the labor and non-labor portions is $25,445.12. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $25,445.12 is multiplied by 130% for a MAR of $33,078.66.
   - 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.

3. Additionally, the provider requested separate reimbursement for implantables. Per Rule 28 TAC §134.403(g), "Implantables, when billed separately by the facility … in accordance with subsection (f)(1)(B) … 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 implantables:

   - "Proclaim 7 Elite Generator" with a cost per unit of $34,210.00;
   - "Impl Spnl St. Jude Octrode L" with a cost per unit of $3,215.00 at 2 units, for a total cost of $6,430.00;
   - "Impl Anchor Lead Cinch" with a cost per unit of $67.00 at 2 units, for a total cost of $134.00.

The total net invoice amount (exclusive of rebates and discounts) is $40,774.00. 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 $1,656.40. The total recommended reimbursement amount for the implantable items is $42,430.40.

4. The total recommended reimbursement for the disputed services is $75,509.06. The insurance carrier paid $66,296.56. The amount due is $9,212.50. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has established that additional payment is due.
As a result, the amount ordered is $9,212.50.

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 $9,212.50, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 25, 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.