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**
COLUMBIA MUTUAL INSURANCE CO.

**MFDR Tracking Number**
M4-20-0992-01

**Carrier's Austin Representative**
Box Number 53

**MFDR Date Received**
December 17, 2019

**Response Submitted By**
Hoffman, Kelley, Lopez, LLP

## *REQUESTOR'S POSITION SUMMARY*

"Underpaid/denied APC. CPT 26356"

## *RESPONDENT'S POSITION SUMMARY*

"The OR services billed by the provider were reimbursed in accordance with the Ambulatory Payment codes classification with the appropriate percentage increase for Texas workers' compensation reimbursement."

## *SUMMARY OF DISPUTE*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| June 4, 2019 | Outpatient Hospital Services | $1,804.48 | $1,804.48 |

## *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:
   - 353 – THIS CHARGE WAS REVIEWED PER THE ATTACHED INVOICE.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

### 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 denied disputed services with claim adjustment reason code:
   - 45 – "Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement."

   Review of the submitted documentation finds no information to support that the disputed services were subject to a contracted fee arrangement between the parties to this dispute.

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.

   Rule 28 TAC §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed hospital facility services. Separate reimbursement for implants was not requested.

   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 26356 has status indicator J1, for procedures paid at a comprehensive rate. All covered services are packaged with the primary billed "J1" procedure. This code is assigned APC 5113. The OPPS Addendum A rate is $2,623.34, which is multiplied by 60% for an unadjusted labor amount of $1,574.00, in turn multiplied by facility wage index 0.9736 for an adjusted labor amount of $1,532.45. The non-labor portion is 40% of the APC rate, or $1,049.34. The sum of the labor and non-labor portions is $2,581.79.

     Per 42 *Code of Federal Regulations* §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the cost of a service exceeds both 1.75 times the OPPS payment and also the fixed-dollar threshold of $4,825, the outlier payment is 50% of the amount in excess of 1.75 times the OPPS payment. Per Medicare's OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this facility as 0.281. This ratio is multiplied by the billed charge of $14,160.50 for a cost of $3,979.10. The sum of packaged costs is $1,983.28, which is added to the service cost for a total cost of $5,962.38. In this case, the cost of services exceeds the fixed-dollar threshold of $4,825. This cost exceeds 1.75 times the OPPS payment by $1,444.25. Half of that amount is $722.13. This amount is the outlier payment.

     The APC payment of $1532.45 is added to the outlier payment of $722.13 for a total Medicare facility specific amount (including outlier payment) of $3,303.92. This amount is multiplied by 200% for a MAR of $6,607.83.

   - 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.

   The total recommended reimbursement for the disputed services is $6,607.83. The insurance carrier paid $3,851.32. The requestor is seeking additional reimbursement of $1,804.48. This amount is recommended.

Conclusion

For the reasons above, DWC finds that additional payment is due. As a result, the amount ordered is $1,804.48.

## *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 $1,804.48, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

| | Grayson Richardson | January 10, 2020 |
|---|---|---|
| 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.