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
Pine Creek Medical Center

Respondent Name
Seabright Insurance Co

MFDR Tracking Number
M4-16-0836-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center was paid a total of $55,326.04 for an outpatient procedure however, claim remains under paid for CPT codes and implants."

Amount in Dispute: $11,544.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 8, 2015. The insurance carrier did not submit a response for consideration in this review. Per 28 Texas Administrative Code §133.307(d)(1) states, "Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." Subsequently, this decision will be based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10, 2015	63685, 63650, 63650, Rev Code 278	11,544.69	$5,010.63

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 acute care hospital 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 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - 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
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the additional recommended payment for the implantable items in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is regarding outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403(f), which 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:
>
> (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 in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

The facility's total billed charges for the separately reimbursed implantable items are $82,700.00. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

Reimbursement for the disputed services is calculated as follows:

- Procedure code C1778 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1787 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1820 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1897 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 63685 has a status indicator of J1, which denotes packaged Part B services paid through a comprehensive APC. All covered Part B services on the claim are packaged with the primary "J1" service (except services with status indicators F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services). These services are classified under APC 0318, which, per OPPS Addendum A, has a payment rate of $26,162.39. This amount multiplied by 60% yields an unadjusted labor-related amount of $15,697.43. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $14,931.40. The non-labor related portion is 40% of the APC rate or $10,464.96. The sum of the labor and non-labor related amounts is $25,396.36. This amount multiplied by 130% yields a MAR of $33,015.27.
- Procedure code 63650 has a status indicator of J1. Review of Addendum J for CY2015 at https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1613-FC-Addenda.zip, finds this a secondary procedure that does not qualify for a complexity-adjusted APC and is therefore packaged into the comprehensive procedure 63685. No additional payment is recommended.
- Procedure code 63650 has a status indicator of J1. Review of Addendum J for CY2015 at https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1613-FC-Addenda.zip, finds this a secondary procedure that does not qualify for a complexity-adjusted APC and is therefore packaged into the comprehensive procedure 63685. No additional payment is recommended.

2. Additionally, the provider requested separate reimbursement of implantables. Per §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 that the separate implantables include:
   - Imp Medt lead 60cm 1x8 compact as identified in the itemized statement and labeled on the invoice as “lead 977A260 Mrics compact” with a cost per unit of $2,401.00 x 2 units for a total cost of $4,802.00.
   - Imp Medt neurostimulator as identified in the itemized statement and labeled on the invoice as “INS 97714 restor sensor Mrics” with a cost per unit of $17,275.00.
   - Imp Medt charging system as identified in the itemized statement and labeled on the invoice as “Charging sys 97754” with a cost per unit of $2,151.00
   - Imp medt progrmmr w/antenna as identified on the itemized statement and labeled on the invoice as “Prog 97740 Patient Mric” with a cost of $1,071.00
   - "Imp medt trial cable" as identified in the itemized statement and labeled on the invoice as "cable 355531 multi-lead" with a cost per unit of $200.00.

   The total net invoice amount (exclusive of rebates and discounts) is $25,499.00. 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 $1,822.40. The total recommended reimbursement amount for the implantable items is $27,321.40.
3. The total allowable reimbursement for the services in dispute is $60,336.67. This amount less the amount previously paid by the insurance carrier of $55,326.04 leaves an amount due to the requestor of $5,010.63. 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 $5,010.63.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,010.63 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 4, 2016
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 Texas Administrative Code §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 with the Division. **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.