



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-17-1794-02

Carrier's Austin Representative

Box Number 45

MFDR Date Received

February 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: \$360.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with the Composite APC methodology 71260 and 74177 fall into APC 8006."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 7, 2016 to October 8, 2016, Outpatient Hospital Services, \$360.43, \$0.00

FINDINGS AND DECISION

This amended findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent. 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 acute care hospital 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
 - 802 – charge for this procedure exceeds the opps schedule allowance.
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 243 – The charge for this procedure was not paid since the value of this procedure is included/ bundled within the value of another procedure performed.
 - 615 – modifier 91 – repeat clinical dx lab test
 - 56 – significant, separately identifiable e/m service rendered.
 - W3 – Additional payment made on appeal/reconsideration.

Issues

- What is the applicable rule for determining reimbursement for the disputed services?
- What is the recommended payment amount for the services in dispute?
- Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payments, 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 with the application of minimal modifications as set forth in the rule.

Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

2. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 96361 has status indicator S denoting a significant OPPS procedure with separate APC payment — not subject to multiple-procedure reduction. This is classified under APC 5691, which, per OPPS Addendum A, has a payment rate of \$30.87, multiplied by 60% yields an unadjusted labor-related amount of \$18.52, which is multiplied by the facility's annual wage index of 0.8026 for an adjusted labor-related amount of \$14.86. The non-labor related portion is 40% of the APC rate or \$12.35. The sum of the labor and non-labor portions is \$27.21. The cost of these services does not exceed the annual fixed-dollar threshold of \$3,250. The outlier payment is \$0. The Medicare facility specific reimbursement is \$27.21, which is multiplied by 200% for a MAR of \$54.42.
- Procedure codes 85007, 80053, 83690, 82150, 82565, 85014, 85025, 85610, 85730, 81003, and 81025 have status indicators of Q4 denoting conditionally packaged laboratory services. Separate payment is allowed at Clinical Laboratory Fee Schedule rates if the bill contains only status Q4 HCPCS codes listed in the CLFS; otherwise, payment for these services is included in the reimbursement for the primary service(s) performed on the same date. Separate reimbursement for these items is not recommended.

- Procedure codes 70450, 71260, and 74177 have status indicator Q3 denoting conditionally packaged codes paid through a composite APC. Services assigned to a composite APC are major components of a single episode of care for which the hospital receives one payment for any combination of designated procedures. If a “without contrast” CT and a “with contrast” CT are billed together, APC 8006 is assigned instead of APC 8005. These services are assigned to composite APC 8006, for computed tomography (CT) services including contrast. If a composite includes multiple line items, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the bill. This line is assigned status indicator S denoting a significant OPPS procedure with separate APC payment — not subject to multiple-procedure reduction. Per OPPS Addendum A, APC 8006 has a payment rate of \$493.91, multiplied by 60% yields an unadjusted labor-related amount of \$296.35, which is multiplied by the facility's annual wage index of 0.8026 for an adjusted labor-related amount of \$237.85. The non-labor related portion is 40% of the APC rate, or \$197.56. The sum of the labor and non-labor amounts is \$435.41. The cost of these services does not exceed the annual fixed-dollar threshold of \$3,250. The outlier payment is \$0. The Medicare facility specific reimbursement is \$435.41, which is multiplied by 200% for a MAR of \$870.82.
- Procedure code 99284 has status indicator J2 denoting hospital, clinic or emergency room visits (including observation and critical care services) that may be subject to composite payment if certain other services are billed in combination. This service is classified under APC 5024, which, per OPPS Addendum A, has a payment rate of \$326.99, multiplied by 60% yields an unadjusted labor-related amount of \$196.19, which is multiplied by the facility's annual wage index of 0.8026 for an adjusted labor-related amount of \$157.46. The non-labor related portion is 40% of the APC rate or \$130.80. The sum of the labor and non-labor portions is \$288.26. The cost of these services does not exceed the annual fixed-dollar threshold of \$3,250. The outlier payment is \$0. The Medicare facility specific reimbursement is \$288.26, which is multiplied by 200% for a MAR of \$576.52.
- Procedure codes Q9967, J2270, and J7040 have status indicator N denoting packaged codes with no separate payment — these items are integral to the total service package; reimbursement is included in the payment for the primary services.
- Procedure code 96374, October 7, 2016, has status indicator S denoting a significant OPPS procedure with separate APC payment — not subject to multiple-procedure reduction. This is classified under APC 5693, which, per OPPS Addendum A, has a payment rate of \$92.40, multiplied by 60% yields an unadjusted labor-related amount of \$55.44, which is multiplied by the facility's annual wage index of 0.8026 for an adjusted labor-related amount of \$44.50. The non-labor related portion is 40% of the APC rate or \$36.96. The sum of the labor and non-labor portions is \$81.46. The cost of these services does not exceed the annual fixed-dollar threshold of \$3,250. The outlier payment is \$0. The Medicare facility specific reimbursement is \$81.46, which is multiplied by 200% for a MAR of \$162.92.
- Procedure code 36415, October 8, 2016, has status indicator Q4 denoting conditionally packaged laboratory services, payment for the packaged services is included in the reimbursement for procedure code 96374, billed on the same date.
- Procedure codes J2270 and J1885, October 8, 2016, have status indicator N denoting packaged codes with no separate payment — these items are integral to the total service package; reimbursement is included in the payment for the primary services.
- Per Medicare policy, procedure code 96372, performed October 8, 2016, may not be reported with procedure code 96374 billed on the same claim. Reimbursement for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed this service with a modifier; however, review of the submitted information finds that the documentation does not support the modifier as billed. Separate payment is not recommended.

- Procedure code 96374, October 8, 2016, has status indicator S denoting a significant OPPTS procedure with separate APC payment — not subject to multiple-procedure reduction. This is classified under APC 5693, which, per OPPTS Addendum A, has a payment rate of \$92.40, multiplied by 60% yields an unadjusted labor-related amount of \$55.44, which is multiplied by the facility's annual wage index of 0.8026 for an adjusted labor-related amount of \$44.50. The non-labor related portion is 40% of the APC rate, or \$36.96. The sum of the labor and non-labor portions is \$81.46. The cost of these services does not exceed the annual fixed-dollar threshold of \$3,250. The outlier payment is \$0. The Medicare facility specific reimbursement is \$81.46, which is multiplied by 200% for a MAR of \$162.92.
3. The total recommended payment for the services in dispute is \$1,827.60. The insurance carrier has previously paid \$1,897.39. The amount due to the requestor is \$0.00. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the amended findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division 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 information submitted by the parties, pursuant to Texas Labor Code §413.031, the division has determined the requestor is not entitled to additional reimbursement. Pursuant to a grant of authority from the Commissioner of Workers' Compensation to issue, amend or withdraw medical fee dispute resolution findings, decisions and orders, the respondent is hereby ordered to pay \$0.00 additional reimbursement to the requestor for the services in dispute.

Authorized Signature

	Grayson Richardson	March 17, 2017
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 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 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. **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.