



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Orthopedic Hospital

Respondent Name

TX Municipal League Intergovernmental Risk Pool

MFDR Tracking Number

M4-17-2871-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the Hospital contends an additional \$2,962.52 remains owed."

Amount in Dispute: \$2,962.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the dispute charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden, & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2 – 9, 2016	Outpatient hospital services	\$2,962.52	\$0.00

FINDINGS AND DECISION

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers compensation jurisdictional fee schedule adjustment
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 59 – Processed based on multiple or concurrent procedure rules

- 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.

Issues

4. What is the applicable rule that pertains to reimbursement?
5. How is the maximum allowable reimbursement calculated?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement in the amount of \$2,962.52 for outpatient hospital services rendered between June 2 and 9, 2016.

The requestor states, "...an additional \$2,962.52 remains owed."

The respondent states, "...the carrier asserts that it has paid according to applicable fee guidelines..."

The insurance carrier reduced the disputed services with reduction codes, 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

These outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The resources that define the components used to calculate the Medicare payment for OPPS are found below:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf,
 - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.
- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
- **Multiple procedure discounts** - Multiple surgical procedures furnished during the same operative session are discounted. The full amount is paid for the surgical procedure with the highest weight; Fifty percent is paid for any other surgical procedure(s) performed at the same time;

The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

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:

(A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.9615	40% non-labor related	Payment	Maximum allowable reimbursement
29882	5122	T	\$2,395.59	\$2,395.59 x 60% = \$1,437.35	\$1,437.35 x 0.9615 = \$1,382.01	\$2,395.59 x 40% = \$958.24	\$1,382.01 + \$958.24 = \$2,340.25	\$2,340.25 x 200% = \$4,680.50
27405	5122	T	\$1,198.00 (50% reduction applies)	\$1,198.00 x 60% = \$718.80	\$718.80 x 0.9615 = \$691.13	\$1,198.00 x 40% = \$479.20	\$691.13 + \$479.20 = \$1,170.33	\$1,170.33 x 200% = \$2,340.66
27599	5111	T	\$86.17 (50% reduction applies)	\$86.17 x 60% = \$51.70	\$51.70 x 0.9615 = \$49.71	\$86.17 x 40% = \$34.47	\$49.71 + \$34.47 = \$84.08	\$84.08 x 200% = \$168.16

The remaining services are classified as follows:

- Procedure code J1170 has status indicator N reimbursement is included in the payment for the primary services.
- Procedure code J1885 has status indicator N reimbursement is included in the payment for the primary services.
- Procedure code J2704 has status indicator N reimbursement is included in the payment for the primary services.
- Procedure code C1713 has status indicator N reimbursement is included in the payment for the primary services.
- Procedure code C1762 has status indicator N reimbursement is included in the payment for the primary services.
- Procedure code 80048, date of service June 2, 2016, has status indicator Q4, denoting packaged labs reimbursement is included in APC payment for primary services
- Procedure code 85027, date of service June 2, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services.
- Procedure code G8978, date of service June 8, 2016, has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.

- Procedure code G8979, date of service June 8, 2016, has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
 - Procedure code G8980, date of service June 8, 2016, has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
 - Procedure code 97001, date of service June 8, 2016, has status indicator A, denoting services paid by fee schedule or different payment system from OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the item on the date provided. Professional services are paid using the DWC Professional Medical Fee Guideline, Rule §134.203(c). The Medicare rate for this code for 2016 is \$76.83. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 yields a MAR of \$121.93.
 - Procedure code J0690 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J1100 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J2250 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J2405 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J3010 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J7999 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J0690, date of service June 8, 2016, has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
 - Procedure code J1650, date of service June 8, 2016, has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J7120, date of service June 8, 2016, has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J7999, date of service June 8, 2016, has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
3. The total recommended reimbursement for the disputed services is \$7,311.25. The insurance carrier has paid \$7,860.08 leaving an amount due to the requestor of \$0.00. Additional payment is not recommended.

Conclusion

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 submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 23, 2017
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, 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.