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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ALAMO HEIGHTS SURGERY CENTER

Respondent Name
PROPERTY & CASUALTY INSURANCE CO.

MFDR Tracking Number
M4-14-0707-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The EOB we received has the wrong billed amount listed. The billed mount on this claim is $10,398.80. Sedgwick entered the incorrect amount of $1,039.88!"

Amount in Dispute: $4,205.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2013	Ambulatory Surgery Services	$4,205.72	$4,166.51

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 §134.402 sets out the fee guidelines for ambulatory surgical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - 4063 – REIMBURSEMENT IS BASED ON THE PHYSICIAN FEE SCHEDULE WHEN A PROFESSIONAL SERVICE WAS PERFORMED IN THE FACILITY SETTING
   - 90 – ALLOWANCE FOR THIS PROCEDURE WAS CALCULATED BY SUBTRACTING THE BASE CODE VALUE FROM THE NON-BASE CODE VALUE (WHEN PROCEDURES ARE WITHIN THE SAME FAMILY).
   - OA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUNDLING OF SERVICES.
   - CO – THE AMOUNT ADJUSTED DUE TO A CONTRACTUAL OBLIGATION BETWEEN THE PROVIDER AND THE PAYER. IT IS NOT THE PATIENT'S RESPONSIBILITY UNDER ANY CIRCUMSTANCES.
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.

Issues

1. Are the disputed services subject to a contract?
2. Are the insurance carrier's payment reduction reasons supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced payment for disputed services with payment reduction codes 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT."; and CO – "THE AMOUNT ADJUSTED DUE TO A CONTRACTUAL OBLIGATION BETWEEN THE PROVIDER AND THE PAYER. IT IS NOT THE PATIENT'S RESPONSIBILITY UNDER ANY CIRCUMSTANCES." Review of the submitted information finds no documentation to support a contracted fee arrangement between the parties to this dispute. The insurance carrier's payment reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. The insurance carrier reduced payment for disputed services with payment reduction codes 4063 – "REIMBURSEMENT IS BASED ON THE PHYSICIAN FEE SCHEDULE WHEN A PROFESSIONAL SERVICE WAS PERFORMED IN THE FACILITY SETTING"; and 90 – "ALLOWANCE FOR THIS PROCEDURE WAS CALCULATED BY SUBTRACTING THE BASE CODE VALUE FROM THE NON-BASE CODE VALUE (WHEN PROCEDURES ARE WITHIN THE SAME FAMILY)." The insurance carrier did not submit any documentation to support these payment reduction reasons. Review of the submitted information finds that the services are not professional services but rather the facility services of an ambulatory surgical center. As such, Medicare's Physician Fee Schedule does not apply to the disputed services. Nor does the multiple endoscopy payment reduction policy applicable to physicians' services apply to services performed by ASCs. Ambulatory surgical facility services are paid under Medicare's Outpatient Prospective Payment System for Ambulatory Surgery Centers (OPPS/ASC) rule, which also has separate rules regarding multiple procedure payment reduction for surgeries. See *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 14 - Ambulatory Surgical Centers, §40.5. The Division concludes that the insurance carrier's payment reduction reasons are not supported. Therefore, reimbursement will be considered per applicable Division rules and fee guidelines.

3. This dispute relates to ambulatory surgery services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.402(f), which states that "The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent"

4. Reimbursement is calculated as follows:

   - Procedure code 29807, service date August 29, 2013, has a status indicator of A2, which denotes an ambulatory surgical procedure with reimbursement subject to the provisions of §134.402(f)(1)(A). The Fully Implemented ASC Relative Payment Weight for this procedure of 50.7329 multiplied by the Medicare conversion factor of 42.917 results in a fully implemented payment amount of $2,177.30. This amount is divided into two halves representing the labor-related and non-labor-related portions of $1,088.65 each. The unadjusted labor-related portion is multiplied by the annual wage index of 0.8936 for the facility location to determine the geographically adjusted labor-related amount of $972.82. This geographically adjusted labor-related portion is added back to the non-labor half to arrive at the Medicare ASC facility reimbursement amount of $2,061.47. This amount multiplied by the Division's conversion factor of 235% results in a payment rate of $4,844.45. This procedure is subject to Medicare's multiple procedure payment reduction policy. The first unit of the highest paying procedure is paid at 100%; all other such services are paid at 50%. This procedure is the highest paying procedure performed this date. The total MAR for 1 unit is $4,844.45. This amount is recommended.

   - Procedure code 29822, service date August 29, 2013, has a status indicator of A2, which denotes an ambulatory surgical procedure with reimbursement subject to the provisions of §134.402(f)(1)(A). The Fully Implemented ASC Relative Payment Weight for this procedure of 27.6089 multiplied by the Medicare conversion factor of 42.917 results in a fully implemented payment amount of $1,184.89. This amount is

divided into two halves representing the labor-related and non-labor-related portions of $592.45 each. The unadjusted labor-related portion is multiplied by the annual wage index of 0.8936 for the facility location to determine the geographically adjusted labor-related amount of $529.41. This geographically adjusted labor-related portion is added back to the non-labor half to arrive at the Medicare ASC facility reimbursement amount of $1,121.85. This amount multiplied by the Division's conversion factor of 235% results in a payment rate of $2,636.36. This procedure is subject to multiple procedure payment reduction. The first unit of the highest paying procedure is paid at 100%; all other such services are paid at 50%. This procedure is not the highest paying procedure performed this date. The total MAR for 1 unit is $1,318.18. This amount is recommended.

5. The total recommended payment for the services in dispute is $6,162.63. The insurance carrier has paid $1,996.12. The additional balance due is $4,166.51. 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 $4,166.51.

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 $4,166.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	January 16, 2015
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 MDR 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.