



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

Surgery Specialty Hospitals of America, S.E.

Respondent Name

Maryland Casualty Co

MFDR Tracking Number

M4-15-1538-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier is required to reimburse Provider \$10,592.53 pursuant to the Outpatient Fee Guideline. The Carrier made a partial payment of \$8,850.53. Therefore, the Carrier is required to reimburse Provider an additional amount of \$1,742.00, plus any and all applicable interest."

Amount in Dispute: \$1,742.00

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 disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2014	Outpatient Hospital Services	\$1,742.00	\$1,742.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 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 recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.403 states in pertinent part (f) 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; unless (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.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 63030 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0208, which, per OPPS Addendum A, has a payment rate of \$4,003.31. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,401.99. This amount multiplied by the annual wage index for this facility of 0.9884 yields an adjusted labor-related amount of \$2,374.13. The non-labor related portion is 40% of the APC rate or \$1,601.32. The sum of the labor and non-labor related amounts is \$3,975.45. 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 total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.36. This ratio multiplied by the billed charge of \$19,998.00 yields a cost of \$7,199.28. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$3,975.45 divided by the sum of all APC payments is 95.50%. The sum of all packaged costs is \$5,242.00. The allocated portion of packaged costs is \$5,006.36. This amount added to the service cost yields a total cost of \$12,205.64. The cost of these services exceeds the annual fixed-dollar threshold of \$2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is \$5,248.60. 50% of this amount is \$2,624.30. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$6,599.75. This amount multiplied by 200% yields a MAR of \$13,199.50.
3. The total allowable reimbursement for the services in dispute is \$13,573.74. The amount previously paid by the insurance carrier is \$8,850.53. The requestor is seeking additional reimbursement in the amount of \$1,742.00. 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 \$1,742.00.

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 \$1,742.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

March , 2015

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.