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
Surgery Specialty Hospitals of America S.E.

Respondent Name
Safety National Corp

MFDR Tracking Number
M4-16-2002-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the Carrier did not make payment according to the Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula."

Amount in Dispute: $1,706.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment for 622273.360 and 99285.450 each do not exceed both thresholds. As such, no Outlier payment is due."

Response submitted by: Corvel, 10000 North Central Expressway, Suite 300, Dallas, Texas 75287

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2015	Outpatient hospital services	$1,706.91	$1,706.91

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

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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - P12 – Workers compensation jurisdictional fee schedule adjustment
    - 18 – Exact duplicate claim/service

Issues

1. What is the Medicare payment rule?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are for Outpatient Hospital Services with dates of service June 4, 2015. 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 Medicare facility specific reimbursement amount is explained at, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf as:

> *"The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.*
>
> *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. You may also receive the following payments in addition to standard OPPS payments:"*

The facility specific reimbursement amount is calculated as follows:

Payment rate found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html **Geographic adjustment**

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider	40% non-labor related	Payment
62273	0207	T	$672.06	$672.06 x 60% = $403.24	$403.24 x 0.9679 = $390.30	$672.06 x 40% = $268.82	$390.30 + $268.82 = $659.12
99285	0616	Q3	$492.69	$492.69 x 60% = $295.61	$295.61 x 0.9679 = $286.12	$492.69 x 40% = $197.08	$286.12 + $197.08 = $483.20

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APCS as follows:

10.1.1 - Payment Status Indicators

> *An OPPS payment status indicator is assigned to every HCPCS code. 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. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under*

the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

10.2 - 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. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

The Medicare Claims Processing manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf , Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 10.7 states, in pertinent part,

"B*eginning in CY 2005, for hospitals only, CMS implemented the use of a fixed-dollar threshold to better target outlier payments to complex and costly services that pose hospitals with significant financial risk. The current hospital outlier policy is calculated on a service basis using both fixed-dollar and multiple thresholds to determine outlier eligibility.*

The current outlier payment is determined by:

• Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass-through status to payment for the associated procedure, by ***multiplying the total charges for OPPS services by each hospital's overall CCR*** *(see §10.11.8 of this chapter); and*

• Determining whether the ***total cost for a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year; and***

• If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPPS payment.

The total cost of all packaged items and services, including the cost of uncoded revenue code lines with a revenue code status indicator of "N", that appear on a claim is allocated across all separately paid OPPS services that appear on the same claim. The proportional amount of total packaged cost allocated to each separately paid OPPS service is based on the percent of the APC payment rate for that service out of the total APC payment for all separately paid OPPS services on the claim*."*

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; 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.

Review of the submitted medical claim finds implants were not requested. The maximum allowable reimbursement for the services in dispute listed on DWC 60 is calculated as follows:

- Procedure code 62273. Per the OPPS Facility-Specific Impacts file, lists the cost-to-charge ratio for this provider as 0.291. This ratio multiplied by the billed charge of $6,900.00 yields a cost of $2,007.90. The APC payment for these services of $659.12 divided by the sum of all APC payments is 57.70%. The sum of all packaged costs is $2,068.47. The allocated portion of packaged costs is $1,193.51. This amount added to the service cost yields a total cost of $3,201.41. The cost of these services exceeds the annual fixed-dollar threshold of $2,775. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,047.95. 50% of this amount is $1,023.98. The total Medicare facility specific reimbursement amount for this line, **including** outlier payment, is $1,683.10. This amount multiplied by 200% yields a MAR of $3,366.19.
- Procedure code 99285. The total Medicare facility specific reimbursement amount for this line is $483.20. This amount multiplied by 200% yields a MAR of $966.40.

3. The total allowable reimbursement for the services in dispute is $4,332.59. The amount previously paid by the insurance carrier is $2,284.63. The requestor is seeking additional reimbursement in the amount of $1,706.91. 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 $1,706.91.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,706.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April 12, 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, 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.