



TEXAS DEPARTMENT OF INSURANCE

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

GENERAL INFORMATION

Requestor Name

Texas Health of Arlington

Respondent Name

California Insurance Company

MFDR Tracking Number

M4-16-3584-01

Carrier's Austin Representative

Box Number 06

MFDR Date Received

August 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of \$1,216.77 for APC # 0053. Allowing this at 200% would yield a fair and reasonable allowance of \$2,433.54. For the APC the allowable amount due totaled is \$2,433.54. Based on your payment of 2,39.73 for the APC a supplemental payment is still due of \$48.85 on the APC alone, at this time."

Amount in Dispute: \$48.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The APC rate in effect on the DOS was \$1,228.33. Sixty percent of this amount (\$736.99) is multiplied by a wage index of 0.9512 for an adjusted amount of \$701.04. The remaining forty percent (\$491.33) is then added for a wage adjusted APC of \$1,192.36. The adjusted APC is then multiplied by 200% for a total adjusted amount due of \$2,384.72."

Response Submitted by: Stone Loughlin, & Swanson, LLP

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 29 - 30, 2015, Outpatient Hospital Services, \$48.85, \$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

- 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 services provided in outpatient hospital services.
3. 28 Texas Administrative Code §102.3 sets out guidelines for computation of time.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 222 – Charge exceeds Fee Schedule allowance
 - ANSIP12 – Workers compensation jurisdictional fee schedule adjustment
 - ANSIW3 – Additional payment made on appeal/reconsideration

The services in dispute are for outpatient hospital services and are therefore 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 may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPSS services which are:

1. **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.
2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPSS 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 OPSS 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, OPSS Addenda, Addendum D1.
3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPSS 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.

Issues

1. Was the request for MFDR timely?
2. What is the applicable fee pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted medical claim finds a date of service July 29 – 30, 2015. The date stamp of the DWCO60 shows a received date of August 1, 2016. 28 Texas Administrative Code §102.3(a)(3) states in pertinent part;

Due dates and time periods under this Act shall be computed as follows:

(3) unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day.

One year from the date of service (July 30, 2015) was Saturday, July 30, 2016. Pursuant to the above, the period is extended to the next working day or Monday, August 1, 2016. Therefore, 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 service in dispute is reimbursed based on the following:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index/0.9512	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
26418	T	0053	\$1,228.33	\$1,228.33 X 60% = \$737.00	\$737.00 X 0.9512 = \$701.03	\$1,228.33 X 40% = \$491.33	\$701.03 + \$491.33 = \$1,192.36	\$1,192.36 X 200% = \$2,384.72
							Total	\$2,384.72

3. The maximum allowable reimbursement for the eligible service is \$2,384.72. The carrier paid \$2,384.72. No additional payment is due.

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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August , 2016
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.