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
Surgery Specialty Hospitals of America SE

Respondent Name
ACIG Insurance Co

MFDR Tracking Number
M4-19-0675-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 8, 2018

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: $7,622.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…ACIG properly reimbursed Surgery Specialty in accordance with the Division Fee Guidelines."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2017	Outpatient Hospital Services	$7,622.90	$7,273.26

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 State Fee Schedule Adj

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?

Findings

1. The requestor is seeking additional reimbursement in the amount of $7,622.90 for outpatient hospital services rendered on October 24, 2017. The insurance carrier reduced disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment.

   28 TAC §134.403 (d) 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 Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4. The application of this payment policy in conjunction with the Division fee guideline is discussed below.

   28 TAC §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;

   Review of the medical bill finds separate payment for implants was not requested. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) and Status Indicator for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. 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 Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates and Status Indicators in the OPPS final rules, available from www.cms.gov.

   The maximum allowable reimbursement based on the above is calculated as follows:

   - Procedure code 29888 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5114. The OPPS Addendum A rate is $5,221.57, multiplied by 60% for an unadjusted labor amount of $3,132.94, in turn multiplied by the facility wage index of 0.972 for an adjusted labor amount of $3,045.22. The non-labor portion is 40% of the APC rate, or $2,088.63. The sum of the labor and non-labor portions is $5,133.85.

     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 exceeds the fixed-dollar threshold of $3,825, 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 0.246. This ratio is multiplied by the billed charge of $30,375.00 for a cost of $7,472.25. 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 $5,133.85 divided by the sum of APC payments is 100.00%. The sum of packaged costs is $9,728.39. The allocated portion of packaged costs is $9,728.39, which is added to the service cost ($7,472.25) for a total cost of $17,200.64. The cost of services exceeds the fixed-dollar threshold of $3,825. The amount by which the cost exceeds 1.75 times the OPPS payment is $8,216.40. Half

of this amount is $4,108.20. The Medicare facility specific amount ($5,133.85 + $4,108.20) of $9,242.05 is multiplied by 200% for a MAR of $18,484.10.

The total recommended reimbursement for the disputed services is $18,484.10. The insurance carrier paid $11,210.84. The amount due is $7,273.26. The carrier's reduction is not supported.

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 $7,273.26.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $7,273.26, 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	November , 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.