



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 Fort Worth

Respondent Name

City of Fort Worth

MFDR Tracking Number

M4-15-3590-01

Carrier's Austin Representative

Box Number 04

MFDR Date Received

June 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After a payment of \$16,073.83, there is a balance due of \$69.76."

Amount in Dispute: \$69.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains reimbursement for the charges in question were made based on the division adopted medical fee guideline and payment policies in effect at the time services were rendered."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2014	29827, 29824, 23430	\$69.76	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation state fee schedule adju
 - 59 – Allowance based on multiple surgery guidelines
 - RD7 – Multiple procedure / 1st procedure
 - RD8 – Multiple procedure / 2nd Procedure (50%)

- RD9 – Multiple procedure /3rd or subsequent (50%)

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 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.

(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.

The maximum allowable reimbursement for the services in dispute will be calculated as follows:

- Procedure code 29827 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 0042, which, per OPPS Addendum A, has a payment rate of \$4,259.01. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,555.41. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$2,430.71. The non-labor related portion is 40% of the APC rate or \$1,703.60. The sum of the labor and non-labor related amounts is \$4,134.31. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$4,134.31 divided by the sum of all S and T APC payments of \$8,036.93 gives an APC payment ratio for this line of 0.514414, multiplied by the sum of all S and T line charges of \$13,990.25, yields a new charge amount of \$7,196.78 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$4,134.31. This amount multiplied by 200% yields a MAR of \$8,268.62.
- Procedure code 29824 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 50%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$4,259.01. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,555.41. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$2,430.71. The non-labor related portion is 40% of the APC rate or \$1,703.60. The sum of the labor and non-labor related amounts is \$4,134.31. Per Medicare Claims Processing Manual,

CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$2,067.16 divided by the sum of all S and T APC payments of \$8,036.93 gives an APC payment ratio for this line of 0.257208, multiplied by the sum of all S and T line charges of \$13,990.25, yields a new charge amount of \$3,598.40 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$2,067.16. This amount multiplied by 200% yields a MAR of \$4,134.32.

- Procedure code 23430 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 50%. These services are classified under APC 0051, which, per OPSS Addendum A, has a payment rate of \$3,781.64. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,268.98. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$2,158.25. The non-labor related portion is 40% of the APC rate or \$1,512.66. The sum of the labor and non-labor related amounts is \$3,670.91. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$1,835.46 divided by the sum of all S and T APC payments of \$8,036.93 gives an APC payment ratio for this line of 0.228378, multiplied by the sum of all S and T line charges of \$13,990.25, yields a new charge amount of \$3,195.07 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$1,835.46. This amount multiplied by 200% yields a MAR of \$3,670.89.

2. The total allowable reimbursement for the services in dispute is \$16,073.83. This amount less the amount previously paid by the insurance carrier of \$16,073.83 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

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 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July , 2015
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.