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 Fort Worth

Respondent Name
Travelers Indemnity Co of Conn

MFDR Tracking Number
M4-15-3885-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We respectfully ask that you reprocess this line item charge at the correct APC allowable at 200% per the appropriate fee schedule of 3/01/2008, minus their pervious payment."

Amount in Dispute: $34.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends the services in dispute have been properly reimbursed in accordance with the Division's outpatient fee schedule."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2014	Outpatient Hospital Services	$34.62	$34.62

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 facility services provided in an acute care hospital.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance

Issues

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

Findings

1. This dispute is for outpatient surgical services performed in an acute care facility. The applicable rule is 28 Texas Administrative Code 134.403 (f) which states,

> 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

Review of the submitted medical bill did not find a separate request for implantables. Therefore, the services in dispute will be calculated as follows:

- Procedure code 25275 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 0050, which, per OPPS Addendum A, has a payment rate of $2,575.90. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,545.54. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of $1,475.84. The non-labor related portion is 40% of the APC rate or $1,030.36. The sum of the labor and non-labor related amounts is $2,506.20. 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 0.196. This ratio multiplied by the billed charge of $13,921.75 yields a cost of $2,728.66. 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 $2,506.20 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $1,728.50. The allocated portion of packaged costs is $1,728.50. This amount added to the service cost yields a total cost of $4,457.16. 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 $71.31. 50% of this amount is $35.65. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $2,541.86. This amount multiplied by 200% yields a MAR of $5,083.71.

2. The total allowable reimbursement for the services in dispute is $5,083.71. The amount previously paid by the insurance carrier is $4,977.78. The requestor is seeking additional reimbursement in the amount of $34.62. 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 $34.62.

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 $34.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August 31, 2015
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.