



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

City of Fort Worth

MFDR Tracking Number

M4-16-1149-01

Carrier's Austin Representative

Box Number 4

MFDR Date Received

January 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For the APC the allowable amount due totaled is \$7,358.62. Based on their payment of \$7,305.64 for the APC a supplemental payment is still due of \$52.98 on the APC alone, at this time."

Amount in Dispute: \$52.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review the bill in question, our recommendation is to agree with the recommendation from Corvel and no additional money is recommended."

Response Submitted by: WellComp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2015	24342	\$52.98	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 acute care hospital fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 234 – This procedure is not paid separately
 - P12 – Workers' Compensation State Fee Schedule Adj

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is regarding outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 24342 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 0051, which, per OPPS Addendum A, has a payment rate of \$3,763.00. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,257.80. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$2,147.62. The non-labor related portion is 40% of the APC rate or \$1,505.20. The sum of the labor and non-labor related amounts is \$3,652.82. 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 \$2,775, 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 0.198. This ratio multiplied by the billed charge of \$7,737.25 yields a cost of \$1,531.98. 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 \$3,652.82 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$2,756.45. The allocated portion of packaged costs is \$2,756.45. This amount added to the service cost yields a total cost of \$4,288.43. 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 \$0.00. The total Medicare facility specific reimbursement amount for this line is \$3,652.82. This amount multiplied by 200% yields a MAR of \$7,305.64.
2. The total allowable reimbursement for the services in dispute is \$7,305.64. This amount less the amount previously paid by the insurance carrier of \$7,305.64 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 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	January , 2016 Date
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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, 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 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.