



# 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**

Doctor's Hospital of Laredo

**Respondent Name**

ZNAT Insurance Co

**MFDR Tracking Number**

M4-15-4191-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

August 27, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We have found in this audit they have not paid what we determine is the correct amount per the APC allowable per the new fee schedule that started 3/01/2008..."

**Amount in Dispute:** \$29.69

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Zenith's position is that no additional payment is due to the Provider as charges were reimbursed correctly per the TX Outpatient Facility Guidelines."

**Response Submitted by:** Zenith Insurance Company, P.O. Box 1558 Sarasota, FL 54230-1558

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2014	99283	\$29.69	\$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:
  - P12 – Workers compensation jurisdictional fee schedule adjustment
  - 18 – Exact duplicate charge
  - 193 – Original payment decision is being maintained upon review

**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 relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule. Per §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. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 99283 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0614, which, per OPPS Addendum A, has a payment rate of \$166.45. This amount multiplied by 60% yields an unadjusted labor-related amount of \$99.87. This amount multiplied by the annual wage index for this facility of 0.7926 yields an adjusted labor-related amount of \$79.16. The non-labor related portion is 40% of the APC rate or \$66.58. The sum of the labor and non-labor related amounts is \$145.74. 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 \$145.74. This amount multiplied by 200% yields a MAR of \$291.48.
2. The total allowable reimbursement for the services in dispute is \$291.48. This amount less the amount previously paid by the insurance carrier of \$291.97 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	September , 2015 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.**