



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 Orthopedic Hospital

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-16-1674-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

February 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is the position of the Hospital that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the Carrier in this case."

Amount in Dispute: \$2,414.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment was calculated using the Medicare Fee Guidelines. No additional monies are owed to Requestor."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2015	73218	\$2,414.82	\$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 Hospital Services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time
 - 5261 – Letter – Please see additional message codes for information related to this review.

Issues

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

Findings

1. 28 Texas Administrative Code §134.403 (f) 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;

The service in dispute will be reviewed as follows:

- Procedure code 73218 is classified under APC 0336, which, per OPPS Addendum A, has a payment rate of \$286.41. This amount multiplied by 60% yields an unadjusted labor-related amount of \$171.85. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$166.33. The non-labor related portion is 40% of the APC rate or \$114.56. The sum of the labor and non-labor related amounts is \$280.89. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,775. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$280.89. This amount multiplied by 200% yields a MAR of \$561.78.
2. The total allowable reimbursement for the services in dispute is \$561.78. This amount less the amount previously paid by the insurance carrier of \$561.78 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

March , 2016
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.