



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 HEB

Respondent Name

Zenith Insurance Co

MFDR Tracking Number

M4-18-2710-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Medicare would have reimbursed the provider at the base APC rate of \$5,101.89 for APC 3 0056. Allowing this at 130% as he implants were carved out, would yield a fair and reasonable allowance of \$6,632.46. For the APC the allowable amount due totaled is \$6,632.46. Based on their payment \$6,244.75 which is the billed charges, the APC supplemental payment is still due of \$387.71 on the APC alone at this time.

Amount in Dispute: \$387.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The total fee schedule allowable for these services is \$10,395.06. Zenith distributed the total reimbursement of \$10,395.06 on multiple billed lines (RC274/L4386, RC278, RC278/C1713 and RC360/27822-LT) to comply with TDI-DWC Rule §134.403(e). No additional payment is due to the provider.

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: July 10, 2017, Outpatient Hospital Services, \$387.71, \$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

- 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 acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 370 - This hospital outpatient allowance was calculated according to the APC rate, plus a markup

## Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered on July 10, 2017. The insurance carrier reduced payment for disputed services with claim adjustment reason code 370 – "This hospital outpatient allowance was calculated according to the APC rate, plus a markup."
2. 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.

The calculation of the Medicare facility specific amount is multiplied by 200 % as the health care provider did not request separate payment for the implants. The results are shown below.

- Procedure code 27822 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is assigned APC 5114. The OPPS Addendum A rate is \$5,221.57. This is multiplied by 60% for an unadjusted labor-related amount of \$3,132.94, which is multiplied by the facility wage index of 0.9618 for an adjusted labor amount of \$3,013.26. The non-labor related portion is 40% of the APC rate, or \$2,088.63. The sum of the labor and non-labor portions is \$5,101.89. The Medicare facility specific amount of \$5,101.89 is multiplied by 200% for a MAR of \$10,203.78.
3. The total recommended payment for the service in dispute is \$10,295.78. The carrier paid under revenue code 278 / \$2,049.31, 278 / \$2,009.00, and 370 / \$6,244.75 for a total of \$10,303.06. Additional payment is not 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
April 20, 2018  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must **include a copy of this *Medical Fee Dispute 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.**