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
Doctors Hospital at Renaissance

Respondent Name
Znat Insurance Co

MFDR Tracking Number
M4-19-4351-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…patient did not provide WC information until 2/05/19 we then submitted our bill 3/19/19."

Amount in Dispute: $1,649.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The services in dispute has been paid pursuant to the TX Outpatient Facility Fee Guidelines. No additional payment is due to the provider."

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2018	Outpatient Hospital Services	$1,649.20	$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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

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

Findings

1. The requestor is seeking additional reimbursement in the amount of $1,649.20 for outpatient hospital services rendered on September 7, 2018. The insurance carrier reduced disputed services based on the workers' compensation jurisdictional fee schedule.

   28 TAC §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; 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.

Review of the submitted medical bill finds implants were not requested separately. The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 72170 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V or in this case code 99284.
- Procedure code 70450 has status indicator Q3, for packaged codes paid through a composite. The payment for composite services is calculated below.
- Procedure code 72125 has status indicator Q3, for packaged codes paid through a composite. The payment for composite services is calculated below.
- Procedure code 99284 has status indicator of J2 when the criteria for comprehensive packaging when 8 or more hours observation are billed. The criteria is not met. This code has a status indicator of V and is assigned APC 5024. The OPPS Addendum A rate is $355.53, multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $176.82. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is $319.03. The Medicare facility specific amount of $319.03 is multiplied by 200% for a MAR of $638.06.
- Procedure code 96374 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $95.03. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is $171.47. The Medicare facility specific amount of $171.47 is multiplied by 200% for a MAR of $342.94.
- Procedure code 96375 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $37.03, multiplied by 60% for an unadjusted labor amount of $22.22, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $18.42. The non-labor portion is 40% of the APC rate, or $14.81. The sum of the labor and non-labor portions is $33.23. The Medicare facility specific amount of $33.23 is multiplied by 200% for a MAR of $66.46.

- Procedure codes 70450, and 72125 have status indicator Q3 and is assigned APC 8005. The OPPS Addendum A rate is $274.84, multiplied by 60% for an unadjusted labor amount of $164.90, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $136.69. The non-labor portion is 40% of the APC rate, or $109.94. The sum of the labor and non-labor portions is $246.63. The Medicare facility specific amount of $246.63 is multiplied by 200% for a MAR of $493.26.

2. The total recommended reimbursement for the disputed services is $1,540.72. The insurance carrier paid $1,540.72. 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

		June 27, 2019
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 Rule §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. **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.