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
UT HEALTH HENDERSON

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-19-5248-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 16, 2019

Response Submitted By
No response received from carrier

REQUESTOR'S POSITION SUMMARY

"We received workers' compensation insurance information via voicemail form the adjuster on 2/28/2019. We immediately sent the bill to the carrier upon receipt of this information."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 8, 2018	Emergency Room Visit: 99281	$121.19	$121.19

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 226 -INFORMATION REQUESTED FROM THE BILLING/RENDERING PROVIDER WAS NOT PROVIDED OR NOT PROVIDED TIMELY OR WAS INSUFFICIENT/INCOMPLETE.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 5205 – Cannot review bill without medical notes for date(s) of service. Please submit medical notes with bill to expedite processing.
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.

Issues

1. Did the insurance carrier submit a response for consideration in this review?
2. Are the insurance carrier's reasons for denial of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for American Zurich Insurance Company is Flahive, Odgen & Latson, Attorneys at Law, PC, who acknowledged receipt of a copy of the MFDR request on August 27, 2019.

   28 Texas Administrative Code §133.307(d)(1) provides that if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

2. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 226 -INFORMATION REQUESTED FROM THE BILLING/RENDERING PROVIDER WAS NOT PROVIDED OR NOT PROVIDED TIMELY OR WAS INSUFFICIENT/INCOMPLETE.
   - 5205 – Cannot review bill without medical notes for date(s) of service. Please submit medical notes with bill to expedite processing.

   Review of the submitted information finds that the insurance carrier did not state or describe the missing, insufficient, or incomplete information that it had requested.

   Based on the information presented to MFDR, the submitted information is found to be sufficient and complete. The medical notes are also attached to the bill.

   The insurance carrier's denial reasons are not supported. The services will therefore be reviewed for payment.

3. This dispute regards Emergency Room services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

   Rule 28 TAC §134.403(f)(1) requires the Medicare facility amount be multiplied by 200% for these ER services.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:
   - Procedure code 99281 represents an ER visit assigned APC 5021. The OPPS Addendum A rate is $68.66, this is multiplied by 60% for an unadjusted labor amount of $41.20, and in turn multiplied by the facility wage index of 0.8106 for an adjusted labor amount of $33.40. The non-labor portion is 40% of the APC rate, or $27.46. The sum of the labor and non-labor portions is the Medicare facility specific amount of $60.86. This is multiplied by 200% for a MAR of $121.72.

   The total recommended reimbursement for the disputed services is $121.72. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $121.19. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has not established that additional payment is due. As a result, the amount ordered is $121.19.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $121.19, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 11, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.