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
Midland Memorial Hospital

Respondent Name
Berkley National Insurance Co

MFDR Tracking Number
M4-19-5386-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is the correct allowable."

Amount in Dispute: $128.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains that its calculation is correct and no additional reimbursement is owed."

Response Submitted by: Flahive, Ogden and Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2019	73223	$128.35	$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 or denied the payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained

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 $128.36 for outpatient hospital services rendered on February 14, 2019. The insurance carrier reduced the disputed services based on workers' compensation 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 found implants are not applicable. The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 73223 has status indicator Q3 but as packaging criteria is not met, this line is separately paid. This line is assigned status indicator S with APC 5572.

  The OPPS Addendum A rate is $385.88, multiplied by 60% for an unadjusted labor amount of $231.53, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of $207.66. The non-labor portion is 40% of the APC rate, or $154.35. The sum of the labor and non-labor portions is $362.01.

  The Medicare facility specific amount of $362.01 is multiplied by 200% for a MAR of $724.02.

2. The total recommended reimbursement for the disputed services is $724.02. The insurance carrier paid $727.92. Additional payment is not recommended.

Conclusion

For the reasons stated above, DWC 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 3, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

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