Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Bailey Square Surgery Center

Respondent Name
Fidelity & Guaranty Insurance

MFDR Tracking Number
M4-13-2427-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received payment of $845.52, but per our contract with Texas Workers' Compensation, which is listed on the explanation of review document, we should be reimbursed at $2,157.42."

Amount in Dispute: $2,154.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Carrier issued reimbursement based upon applicable fee guidelines in the amount of $845.22. Requestor asserts that a contracted rate of $2157.42 is applicable to the service date, but has not provided a copy of the contract that it contends is applicable with its medical dispute request. Accordingly, Requestor has failed to provide documentation to show that it is entitled to additional reimbursement as required by 28 TAC 133.307(c)(2)(O).

Response Submitted By: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2012	20680	$2,157.42	$1,338.85

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.402 sets out the guidelines for reimbursement for services provided in ambulatory surgical centers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting

Issues

1. Did the requestor request support calculation of fees?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.402(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR (date of service), or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; The maximum allowable reimbursement will be calculated as follows;

Date of Service	Submitted Code	Amount Billed	Rule 134.402 (f) MAR (Geographically adjusted Medicare ASC reimbursement)
December 14, 2012	20680	$3,321.00	ASC reimbursement divided by 2 multiplied by CBSA city wage index, sum of these two, multiplied by 235% or 932.08÷2=466.04 x 0.9945 = 463.48 466.04 + 463.48 = 929.52 x 235% = 2,184.37
	TOTAL	$3,321.00	$2,184.37

2. The total maximum allowable reimbursement for the services in dispute if $2,184.37. The carrier previously paid $845.52. The remaining balance is $1,338.85. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,338.85.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,338.85 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 23, 2014 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, 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 MDR 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.