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
Houston Orthopedic Surgical Hospital

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-14-1229-01

Carrier's Austin Representative
Box 15

MFDR Date Received
December 31, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Medicare Fee Schedule the expected reimbursement not seeking separate reimbursement on implants if $12,258.12 which is 200%."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2013	29888	$500.00	$500.00

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:
   - Z710 - The charge for this procedure exceeds the fee schedule allowance
   - P303 - This service was reviewed in accordance with your contract
   - 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

- Z547 - Any reduction is in accordance with a Coventry Owned Contract

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. What rule is applicable to reimbursement?

Findings

1. The Austin carrier representative for Indemnity Insurance Co of North America, Downs Stanford PC, acknowledged receipt of the copy of this medical fee dispute on January 8, 2014. 28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received to date. The division concludes that that the insurance Carrier failed to respond within the timeframe required by §133.307(d)(1). The division will base its decision on the information available.

2. The insurance carrier reduced the disputed services based on "Coventry owned contract."

   Although Coventry is listed as a certified network on the Division's webpage, the carrier did not provide convincing evidence that the injured employee is enrolled in this network.

   The Division concludes that the carrier failed to support its reasons for denial of payment. The service in dispute will be reviewed per applicable Division fee guideline.

3. The requestor is seeking additional reimbursement for outpatient hospital services rendered July 31, 2013. 28 Texas Administrative Code §134.403 (e) and (f) are applicable to the disputed service and states in pertinent parts;

   (e) Regardless of billed amount, reimbursement shall be:
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

   (f) 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.

As stated above, no evidence of a contract was provided and review of the submitted medical bill found separate payment for implants was not requested. The maximum allowable reimbursement calculation is:

Date of service	CPT Code	Billed amount	Status Indicator	Medicare allowed	Adjusted APC rate	MAR (adj APC x 200)
July 31, 2013	29888	$25,823.00	T	$5,862.48	$5,834.34	$11,668.68

4. The total allowable for the services in dispute is $11,668.68. The insurance carrier paid $10,501.81. The requestor is seeking $500.00 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 $500.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $500.00, 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	June 7, 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 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.