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
Texas Midwest Surgery Center

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-14-1959-01

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
March 4, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The total claim reimbursement should be $3212.28."

Amount in Dispute: $1,405.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Respondent: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2013	26860, 26540	$1,405.97	$1,405.97

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 reimbursement guidelines for medical services, charges and payments.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 222 – Charge exceeds fee schedule allowance
   - 102 – Multiple surgery rules allow for this procedure to be paid at 50%
   - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Did the requestor support calculations of allowable charges?
2. What is the applicable rule to calculate reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(f) states, "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 CY 2008, published in the November 27, 2007 publication of the Federal Register, 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; or
      (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:
      (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
      (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent. …

   28 Texas Administrative Code §134.402 (d) states, "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section…"

   Review of the submitted documentation finds request for implantables is not applicable therefore, the services in dispute will be calculated at the Medicare ASC Facility reimbursement amount multiplied by 235% or

Submitted Procedure Code	National Reimbursement from Addendum AA	Statistical Area Number	Wage Index for ASC	Divide National Reimbursement by 2	Multiply by National Wade Index	Add to National Reimbursement Divided by 2	Medicare Adjusted ASC Reimbursement	Total MAR
26860	$1,159.36	10180 Abilene, TX	0.8444	1,159.36 ÷ 2 = 579.68	579.68 x 0.8444 = 489.48	579.68 + 489.48 = 1069.16	$1,069.16	$1069.16 x 235% = $2,512.53
26540	$665.18÷ 50% per Multiple procedure discount = 332.58	10180 Abilene TX	0.8444	332.58 ÷ 2 = 166.29	166.29 x 0.8444 = 140.35	166.29 + 140.35 = 306.64	$306.64	$306.64 x 235% = $720.60
							Total	$3,233.13

2. The total allowable for the disputed services is $3,233.13. The carrier paid $1,806.31. The requestor is seeking $1,405.97. 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 $1,405.97.

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 $1,405.97 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	January , 2015 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.