



# 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 Metro Ortho and Spine Surgery Center, LLC

**Respondent Name**

Liberty Insurance Corp

**MFDR Tracking Number**

M4-15-2560-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

April 14, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Because Liberty Mutual provided the authorization for the medically necessary services to the patient, it is our position the Hospital is entitled to reimbursement."

**Amount in Dispute:** \$103,200.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows: The provider did not request an agreement for payment of services as required under 28 TAC Chapter §134.402. Ambulatory Surgical Center Fee Guidelines for services normally not performed in an ASC. The procedures performed are not payable in an Ambulatory Service Center per Medicare ASC Guidelines and because these services are not normally performed in an ASC, the provider should have initiated an agreement as required under the guidelines as outlined in §134,492 (i)..."

**Response Submitted by:** Liberty Mutual Insurance

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2014	63047, 63048	\$103,200.00	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402 sets out the reimbursement guidelines for services performed in an Ambulatory Surgical Center.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- E533 – This procedure is not allowed for reimbursement to an ambulatory surgery center

### Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

### Findings

1. The insurance carrier denied disputed services with claim adjustment reason code E533 – "This procedure is not allowed for reimbursement to an ambulatory surgery center." 28 Texas Administrative Code §134.402 (d) requires that "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, including the following paragraphs." Review of the submitted information finds;

- a. 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 submitted codes 63047 and 63048 are not found on the Centers for Medicare and Medicaid, ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES for year 2014.

- b. While the Carrier did provide evidence of prior authorization, 28 Texas Administrative Code §134.402 (i) states, If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:

- (1) The agreement may occur before, or during, preauthorization.

- (2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

- (3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:

- (A) the reimbursement amount;

- (B) any other provisions of the agreement; and

- (C) names, titles and signatures of both parties with dates.

- (4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

- (5) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

The insurance carrier's denial reason is supported as no documentation was found to support an agreement was made between the health care provider and the carrier prior to or during the authorization process. The Division finds provisions of Rule 134.402 were not met.

2. The services in dispute do not meet the requirements of Rule 134.402 (i). No additional reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

		July , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

		July , 2015
Signature	Health Care Business Management Director	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, 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 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.**