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
Baylor Surgical Hospital

Respondent Name
Lumbermens Underwriting Alliance

MFDR Tracking Number
M4-15-3476-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services."

Amount in Dispute: $4,261.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute was received however, no position statement was submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 2014	Outpatient hospital services	$4,261.92	$4,261.92

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.28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
2. 28 Texas Administrative Codes 133.240 sets out the rules for medical bill payments and denials.
3. No explanation of benefits was submitted by the requestor or respondent for the disputed services.

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on July 1, 2015. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 Texas Register 3954, "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." Accordingly, this decision is based on the available information.

Issues

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

Findings

1. The requestor states, "Two claims were submitted to the carrier, once on 10-17-2014 via mail and again on 4-15-2015 via fax with no response either via denial or reimbursement." 28 Texas Administrative Codes §133.240(a) states,

> An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

The insurance carrier did not provide any evidence of compliance with the above Rule. Therefore, the requestor's position is supported. These claims will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Coder 134.403 (f) states in pertinent part,

> 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.
>
> (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

The maximum allowable reimbursement will be calculated as follows:

- Procedure code 64633 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0203, which, per OPPS Addendum A, has a payment rate of $1,545.07. This amount multiplied by 60% yields an unadjusted labor-related amount of $927.04. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $881.80. The non-labor related portion is 40% of the APC rate or $618.03. The sum of the labor and non-labor related amounts is $1,499.83. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $1,499.83. This amount multiplied by 200% yields a MAR of $2,999.66.
- Procedure code 64633 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0203, which, per OPPS Addendum A, has a payment rate of $1,545.07. This amount multiplied by 60% yields an unadjusted labor-related amount of $927.04. This amount multiplied by the

annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $881.80. The non-labor related portion is 40% of the APC rate or $618.03. The sum of the labor and non-labor related amounts is $1,499.83. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $749.92. This amount multiplied by 200% yields a MAR of $1,499.84.

- Procedure code 64634 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 64634 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. The total allowable reimbursement for the services in dispute is $4,499.50. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking reimbursement in the amount of $4,261.92. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $4,261.92.

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 $4,261.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August 31, 2015
Signature	Medical Fee Dispute Resolution Officer	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.