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
PINNACLE SURGERY CENTER

Respondent Name
LM INSURANCE CORPORATION

MFDR Tracking Number
M4-18-4118-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the Workers Compensation fee schedule is based on 235% of the Medicare geographically fully implemented adjusted rate."

Amount in Dispute: $1,384.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It appears that this bill was submitted on the incorrect billing form. . . .This should actually have been denied as billed on the wrong form."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 14, 2018	Ambulatory Surgery Center Services	$1,384.25	$1,380.96

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.

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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 medical fee guideline for ambulatory surgery centers.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
4. 28 Texas Administrative Code §133.200 sets out requirements upon insurance carrier receipt of medical bills.
5. 28 Texas Administrative Code §133.240 sets out requirements when insurance carriers pay or deny medical bills.

6. 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.
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - Z652 - RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.

Issues

1. Did the insurance carrier's position statement raise new defenses or denial reasons that were not presented to the requestor prior to the filing of this medical fee dispute?
2. What is the recommended reimbursement for the disputed health care?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent's position statement asserts, "This should actually have been denied as billed on the wrong form."

   Rule §133.200(a), regarding insurance carrier receipt of medical bills from health care providers, requires that upon receipt of a medical bill, an insurance carrier must evaluate each bill for completeness as defined in Rule §133.2, which states that a complete medical bill contains all required fields as set forth in the billing instructions for the appropriate form.

   Rule §133.200(b)(2) requires the carrier to return an incomplete medical bill to the sender within 30 days if it cannot complete the bill by adding missing information already known to the carrier.

   Rule §133.200(c) provides that the proper return of an incomplete medical bill fulfills the insurance carrier's obligations with regard to that bill.

   Rule §133.240 requires the insurance carrier to send an explanation of benefits (EOB) to the provider whenever the carrier pays or denies a medical bill.

   Rules §§ 133.240 (e) and (f) set out required elements an EOB must contain, including, per §§ 133.240(f)(17)(G) and (H), adjustment reason code(s) conforming to the standards described in the rules if the total amount paid does not equal the total amount charged; with explanation of the reason(s) for reduction or denial for any code used to adjust the payment.

   The respondent did not return the bill to the sender as incomplete but rather processed the bill for payment. Review of the carrier's EOB finds no adjustment reason codes nor any notice to the provider indicating the medical bill was incomplete or billed on an incorrect form. The carrier cannot now raise new denial reasons that were not properly presented to the medical provider during the bill review process.

   Rule §133.307(d)(2)(F) requires that the insurance carrier's response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or reasons for reduction or denial of payment as required by Rule §133.240 constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution.

   Upon review of the insurance carrier response, the division finds the respondent has raised new denial reasons or defenses of which the carrier failed to give any notice to the health care provider during the bill review process or prior to the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise these new denial reasons or defenses during MFDR. Any such new denial reasons or defenses will therefore not be considered in this review.

2. This dispute regards ambulatory surgical facility services with payment subject to 28 Texas Administrative Code §134.402(f), requiring the maximum allowable reimbursement (MAR) to be the Medicare ASC amount applying Medicare Ambulatory Surgical Center payment policies and Outpatient Prospective Payment System (OPPS) formula and factors—including ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES—effective for the date of service, as published in the Federal Register, available at http://www.cms.gov.

As specified in Rule §134.402(f)(1)(A), the reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 23700 has a Medicare ASC Addendum AA rate of $737.58. This rate is divided into two halves representing the labor and non-labor related portions of $368.79 each. The labor-related half is multiplied by the facility's wage index of 0.9675 for a geographically adjusted labor amount of $356.80. This is added back to the non-labor half. The sum is the Medicare ASC facility rate of $725.59, which is multiplied by the division conversion factor of 235% for a total MAR of $1,705.14.

3. The total allowable reimbursement for the services in dispute is $1,705.14. The insurance carrier paid $324.18. The amount due to the requestor is $1,380.96. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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 $1,380.96.

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 $1,380.96, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 20, 2018
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.