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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ARISE HEALTHCARE SYSTEM

Respondent Name
HYATT CORP.

MFDR Tracking Number
M4-19-3504-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
March 19, 2019

Response Submitted By
No response submitted for review

REQUESTOR'S POSITION SUMMARY

"Arise billed Gallagher Bassett via mail 08/14/2019 initially receiving a zero pay due to claim denying as duplicate (only one claim was submitted). … the adjustor … advised claim would be processed and paid that was in November 2018. … However, no check has been sent to us …"

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 7, 2018	Outpatient Hospital Services	$4,583.90	$4,583.90

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 hospital facility fee guideline for outpatient services.
3. The division provided a copy of the Medical Fee Dispute Resolution request to the insurance carrier's Austin representative, receipt acknowledged March 26, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "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. 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." The insurance carrier has not responded. Consequently, this decision is based on the information available at the time of review.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – DUPLICATE CLAIM/SERVICE

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 18 – "Duplicate claim/service."

   28 Texas Administrative Code §133.307(d)(2) requires that "upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent."

   Additionally, Rule §133.307(d)(2)(B) requires the respondent to also provide paper copies of:

   > all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider … related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request;

   Rule §133.307(d)(1) further provides that "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."

   The insurance carrier did not respond to the request for medical fee dispute resolution and did not provide any of the information or documents as required by Rule §133.307(d). Accordingly, the findings in this decision are based on the information available at the time of review.

   The requestor asserts their initial bill submission was denied as a duplicate. The insurance carrier has not provided any information to support denial of payment as a duplicate of a previously considered bill.

   The division finds the insurance carriers' denial reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with division fee guidelines.

2. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

   Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed hospital facility services.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 20680 (removal of implant) is assigned APC 5073 with status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. The OPPS Addendum A rate for APC 5073 is $2,324.87. This is multiplied by 60% for an unadjusted labor amount of $1,394.92, which is in turn multiplied by the facility wage index of 0.9764 for an adjusted labor amount of $1,362.00. The non-labor portion is 40% of the APC rate, or $929.95. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $2,291.95. This is multiplied by 200% for a MAR of $4,583.90.
   - Payment for all other services on the bill is packaged with the primary comprehensive J1 service per Medicare policy regarding comprehensive APCs. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details.

   The total recommended reimbursement for the disputed services is $4,583.90. The insurance carrier paid $0.00. The amount due is $4,583.90. 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 findings in this decision are based on the evidence 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 $4,583.90.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent remit to the requestor $4,583.90, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	May 10, 2019
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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.