MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AOS Surgery Center

Respondent Name
Protective Insurance Co

MFDR Tracking Number
M4-21-1269-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 24, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility is in the State of Georgia, we were preauthorized as an out-of-state provider, and therefore should be paid according to Georgia's fee schedule."

Amount in Dispute: $2,736.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent reimbursed Requestor based on the Texas medical fee guidelines established by the Texas Labor Code. Tex. Labor Code §413.015(a) states an insurance carrier shall pay appropriate charges for medical services provided under this subtitle. Therefore, Respondent compliance with this statue by reimbursing the services at rate allowed by the Texas fee schedule."

Response Submitted by: Downs Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2020	29824	$2,736.77	$38.23

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.
2. 28 Texas Administrative Code §134.402 sets out the fee guideline for ambulatory surgical care centers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – Contract/legislated fee arrangement exceeded
   - 352 – Network disc not applicable to procedure billed
   - P12 – Workers' Compensation State Fee Schedule Adj

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Are the insurance carrier's reasons for reduction of payment supported?
3. What rule is applicable to fee guideline calculation?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states, "Our facility is in the State of Georgia, we were preauthorized as an out-of-state provider, and therefore should be paid according to Georgia's fee schedule."

   The requestor is a health care provider that rendered disputed services in the state of Georgia to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration.

   The health care provider has requested medical fee dispute resolution under 28 TAC §133.307. Because the requestor has sought the administrative remedy outlined in 28 TAC §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. The insurance carrier reduced the disputed service based on fee arrangement. Review of the submitted documentation found insufficient evidence to support the injured worker was enrolled in a certified network at the time of service. The service in dispute will be reviewed per the applicable Texas DWC fee guideline discussed below.

3. 28 TAC §134.402 (f)(1)(A) states in pertinent part the reimbursement calculation used for establishing the MAR (maximum allowable reimbursement) shall be the Medicare ASC reimbursement amount in Addendum AA, ASC covered surgical procedures at www.cms.gov. Reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent.

   Review of the submitted medical bill found the disputed service is Procedure Code 29824. This code is not identified as a device intensive procedure. The Medicare ASC reimbursement in Addendum AA on the date of service in dispute is $1,286.26. This amount multiplied by 235% equals a MAR of $3,022.71.

4. The total allowable is $3,022.71. The insurance carrier paid $2,984.48. A balance of $38.23 is due to the requestor.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 above the requestor has established payment is due. As a result, the amount ordered is $38.23.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $38.23, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 30, 2021 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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.