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
Memorial Hermann Surgery Center

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-12-2837-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The allowed amount for this claim should be $684.15. Per your EOB you only allowed $203.66."

Amount in Dispute: $87.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: 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 May 11, 2012. The insurance carrier did not submit a response for consideration in this review. 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." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2011	62310	$87.47	$87.47

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 reimbursement guidelines for ambulatory surgical centers.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 18 – Duplicate claim/service

Issues

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

Findings

1. The insurance carrier reduced the disputed services with claim adjustment reason code 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. 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 following minimal modifications apply:
>
> (1) Reimbursement for non-device intensive procedures shall be:
>
> (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent;

According to Addendum AA, CPT code 62310 is a non-device intensive procedure.

The City Wage Index for The Woodlands, TX is 0.9935.

The Medicare fully implemented ASC reimbursement for code 62310 CY 2011 is $294.00.

To determine the geographically adjusted Medicare ASC reimbursement for code 62310:

The Medicare fully implemented ASC reimbursement rate of $294.00 is divided by 2 = $147.00.

This number multiplied by the City Wage Index is $147.00 X 0.99935 = $146.90

Add these two together $147.00 + $146.90 = $293.90

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%.

$293.90 x 235% = $690.67. The respondent paid $203.66. The requestor is seeking $87.47 this amount is recommended.

3. Pursuant to rule 134.402 the Division finds the requestor is due an additional payment in the amount requested or $874.7.

Conclusion

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 $87.47.

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 $87.47 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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