TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Surgicare at Granbury

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-19-2546

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am enclosing a copy of the EOR, the claim and the Medicare fee schedule for the old CBSA which is what you paid by and the current one which is what you should have paid by. Please review and reprocess and pay accordingly.

Amount in Dispute: $278.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are upholding the original review. Therefore, we are unable to recommend any additional allowance."

Response Submitted by: Avidel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2018	ASC CPT code 64493, -RT, -LT	$278.27	$105.26

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent. 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, effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement

guidelines for ambulatory surgical care services.

3. Per the submitted explanation of benefits, the services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - 59-Processed based on multiple or concurrent procedure rules.
     627-The bilateral procedure rules have been applied to this procedure code.
   - 790-This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 95-Plan procedures not followed.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the applicable fee guideline for the disputed services?
2. Is the requestor entitled to additional reimbursement for ASC services rendered on October 29, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $278.27 for ambulatory surgical care services rendered to the injured worker on October 29, 2018. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.

2. To determine the appropriate reimbursement for non-device intensive procedure CPT code 64493 the division refers to28 Texas Administrative Code §134.402(f)(1)(B).

   28 Texas Administrative Code §134.402(f)(1)(B) 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.

   The following formula is used to determine the MAR:

   - Per Addendum AA, the Medicare ASC reimbursement for code 64493 on the disputed date is $350.15.
   - To determine the geographically adjusted Medicare ASC reimbursement for code 64493 the rate is divided by 2 = $175.07.
   - This number multiplied by the City Wage Index for Granbury, Texas is $175.07 X 0.959 = $167.89.
   - Add these two together = $342.96.
   - Multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $805.96.

   CPT code 64493 was performed bilaterally and is subject to multiple procedure discounting. Per

Medicare Claims Processing Manual, 40.5-Payment for Multiple Procedures effective January 1, 2008, "A procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with "2" in the units field on one line. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting."

The division finds the requestor is due $805.96 for one unit of 64493 and $402.98 for the second unit, for a total of $1,208.94. The respondent paid $1,103.68. As a result, the division finds the requestor is due $105.26 additional reimbursement.

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 $105.26.

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 $105.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		February 15, 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, 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 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. **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.