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
BAYLOR SURGICARE AT OAKMONT

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-2829-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JANUARY 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was originally processed under the 2017 ASC W. C. Case Calculator. It appears that the calculator was not updated in your system when this claim was processed. This is a 2018 claim. Therefore, this should have been processed under the 2018 ASC W.C. Case Calculator."

Amount in Dispute: $7,695.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payment is due for device intensive code 24366."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2018	Ambulatory Surgical Care Services CPT Code 24366	$7,695.58	$0.00

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, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- CAC-18-Exact duplicate claim/service.
- 763-Paid per ASC FG at 235%: implants not applicable or separate reimbursement (w/signed cert) not requested: Rule 134.402(g)
- 878-Appeal (request for reconsideration) previously processed. Refer to rule 133.250(H).
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on January 25, 2018?

Findings

1. The requestor billed $18,349.00 for CPT code 24366 rendered at an ASC on January 25, 2018. The insurance carrier paid $10,258.30. The requestor is seeking medical fee dispute resolution in the amount of $7,695.58.
2. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.
3. To determine the appropriate reimbursement for CPT code 24366 the division refers to 28 Texas Administrative Code §134.402(f).

   A. Per ADDENDUM AA, CPT codes 24366 is a device intensive procedure.

   28 Texas Administrative Code §134.402(f)(2)(A)(i)(ii) 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: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

   The following formula was used to calculate the MAR:

   - Step 1 calculating the device portion of the procedure:

     The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 24366 for CY 2018 = $10,122.92.

     This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 57.25% = $5,795.39.

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare ASC reimbursement rate for code 24366 is $7,799.85.
     The Medicare fully implemented ASC reimbursement rate of $7,799.85 is divided by 2 = $3,899.92.
     This number multiplied by the City Wage Index for Fort Worth, TX $3,899.92 X 0.9590 = $3,740.02.
     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$7,639.94.
     The service portion is found by taking the geographically adjusted rate of $7,639.94 minus the device portion of $5,795.39 = $1,844.55.

     Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,844.55 X 235% = $4,334.69.

     The MAR is determined by adding the sum of the reimbursement for the device portion of $5,795.39 + the service portion of $4,334.69 = $10,130.08. The insurance carrier paid $10,258.30. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		02/28/2019
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.