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

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICARE AT MANSFIELD

Respondent Name
GRAPHIC ARTS MUTUAL INSURANCE

MFDR Tracking Number
M4-19-3383-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MARCH 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2018 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $6,486.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent contends that the correct allowance for the services made subject of this medical fee dispute is $34,133.74…To date, Requestor has received $35,690.33 in connection with these services."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10, 2018	Ambulatory Surgical Care Services CPT Code 63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling."	$4,208.78	$0.00
	Ambulatory Surgical Care Services CPT Code 63650 Percutaneous implantation of neurostimulator electrode array, epidural	$1,139.06	$0.00
	Ambulatory Surgical Care Services CPT Code 63650 Percutaneous implantation of neurostimulator electrode array, epidural	$1,139.06	$0.00
TOTAL		$6,486.90	$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:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - No additional payment recommended as claim paid per state of Texas Medicare fee schedule.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on July 10, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $6,486.90 for ambulatory surgical care services rendered to the injured worker on July 10, 2018. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.
2. The insurance carrier paid $35,690.33 for the disputed services, CPT codes 63685 and 63650 (X2), based upon the fee guideline.
3. To determine the appropriate reimbursement the division refers to the following statutes:

   28 Texas Administrative Code §134.402(b) (6) states,

   > Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   28 Texas Administrative Code §134.402(d) states,

   > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   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."

4. Per ADDENDUM AA, CPT code 63685 is a device intensive procedure.

   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 63685 for CY 2018 = $27,891.79.

     This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 82.77% = $23,086.03.

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 63685 is $22,892.96.
     Per the Medicare fully implemented ASC reimbursement rate of $22,892.96 is divided by 2 = $11,446.48.
     This number multiplied by the City Wage Index for Mansfield, TX $6,454.47 X 0.9590 = $10,977.17.
     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$22,423.65.
     The service portion is found by taking the geographically adjusted rate of $22,423.65 minus the device portion of $23,086.03 = -$662.38.

     Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment -$662.38 X 235% = -$1,556.59.

     The MAR is determined by adding the sum of the reimbursement for the device portion of $23,086.03 + the service portion of -$1,556.59 = $21,529.44. The insurance carrier paid $23,086.03.

5. Per ADDENDUM AA, CPT code 63650 is a device intensive procedure.

   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 63650 for CY 2018 = $6,055.61.

     This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 52.28% = $3,165.87.

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 63650 is $4,594.65.
     Per the Medicare fully implemented ASC reimbursement rate of $4,594.65 is divided by 2 = $2,297.32.
     This number multiplied by the City Wage Index for Mansfield, TX $2,297.32 X 0.9590 = $2,203.12.
     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$4,500.44.
     The service portion is found by taking the geographically adjusted rate of $4,500.44 minus the device portion of $3,165.87 = $1,334.57.

     Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,334.57 X 235% = $3,136.23.

     The MAR is determined by adding the sum of the reimbursement for the device portion of $3,165.87 + the service portion of $3,136.23 = $6,302.10/unit. The insurance carrier paid $6,302.15/unit.

     The requestor billed for two units; therefore, $6,302.10 X 2 = $12,604.20.

6. The division finds the total allowable for ASC services rendered on July 10, 2018 is $34.133.64. The respondent paid $35,690.33. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

		04/11/2019
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.