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 MANSFIELD

Respondent Name
BRADFORD HOLDING COMPANY INC

MFDR Tracking Number
M4-19-3641-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MARCH 29, 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 for Ambulatory Surgical Centers."

Amount in Dispute: The requestor noted on the *Table of Disputed Services* and Position Statement the total amount in dispute as $1,572.41; however, the requestor also noted on the *Table of Disputed Services* the amount in dispute as $1,722.65.

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The first bill, control number 2324, from Baylor Surgicare was denied for timely filing limits due to being submitted 105 days after service. Then, they sent in a reconsideration that was paid on control number 99065. After further review, there is an additional $1,572.41 owed on this claim and it was paid on control number 99088. The check will go out later this week."

Response Submitted by: Novare, LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 26735	$1,722.65	$0.00
	Ambulatory Surgical Care Services CPT Code 26755	$0.00	$0.00
TOTAL		$1,722.65	$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:
   - 29-The time limit for filing has expired.
   - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.
   - 18-Exact duplicate claim/service.
   - 247-A payment or denial has already been recommended for this service.
   - 947-Upheld. No additional allowance has been recommended.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on August 30, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,572.41 for ambulatory surgical care services rendered to the injured worker on August 30, 2018. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.

2. The insurance carrier initially denied reimbursement for the disputed services based upon "29-The time limit for filing has expired." A review of the submitted documentation finds the insurance carrier did not maintain the denial and issued payment of $1,223.47. In response to this dispute the insurance carrier made an additional payment of $1,572.41 on April 18, 2019.

3. 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.

4. Per ADDENDUM AA, CPT code 26735 is a non-device intensive procedure.

   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 was used to calculate the MAR:

   The Medicare fully implemented ASC reimbursement for code 26735 CY 2018 is $1,279.91.

   The Medicare fully implemented ASC reimbursement rate of $1,279.91 is divided by 2 = $639.95.

   This number multiplied by the City Wage Index for Mansfield, Texas is $639.95 X 0.9590 = $613.71.

   Add these two together = $1,253.66.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,946.10.

5. Per ADDENDUM AA, CPT code 26755 is a non-device intensive procedure.

   The following formula was used to calculate the MAR:

   The Medicare fully implemented ASC reimbursement for code 26755 CY 2018 is $111.95.

   The Medicare fully implemented ASC reimbursement rate of $111.95 is divided by 2 = $55.97.

   This number multiplied by the City Wage Index for Mansfield, Texas is $55.97 X 0.9590 = $53.67.

   Add these two together = $109.64.

   To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $257.65. This code is subject to multiple procedure discounting of 50% = $128.82.

6. The total allowable for ASC services rendered on August 30, 2018 is $3,074.92. The respondent paid $3,074.98. The requestor is due the difference between MAR and paid of $0.00.

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 services in dispute.

Authorized Signature

______________________	______________________	04/18/2019
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.