



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

GENERAL MOTORS LLC

MFDR Tracking Number

M4-19-4137-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

MAY 15, 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: \$8,991.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Baylor Surgicare has failed to provide any sufficient reasoning why it is entitled to additional reimbursement, or how the limited documentation submitted justifies additional payment."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 27, 2018	Ambulatory Surgical Care Services CPT Code 63685	\$6,691.66	\$926.29
	Ambulatory Surgical Care Services CPT Code 63650	\$1,149.69	\$10.58
	Ambulatory Surgical Care Services CPT Code 63650	\$1,149.69	\$10.58
TOTAL		\$8,991.04	\$947.45

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.
 - 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
 - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
 - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
 - 18-Exact duplicate claim/service.
 - W3-Additional payment made on appeal/reconsideration.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for ASC services rendered on December 27, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$8,991.04 for ambulatory surgical care services rendered to the injured worker on December 27, 2018.
2. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.
3. The insurance carrier paid \$33,186.19 for the disputed services based upon the fee guideline.
4. 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.
5. 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.
6. 28 Texas Administrative Code §134.402(b) defines "'ASC device portion' means the portion of the ASC payment rate that represents the cost of the implantable device, and is calculated by applying the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) device offset percentage to the OPPS payment rate."

The disputed services are defined as:

- 63650- Percutaneous implantation of neurostimulator electrode array, epidural.
- 63685- Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling.

7. To determine the appropriate reimbursement for CPT codes 63650 and 63685 the division refers to 28 Texas Administrative Code §134.402(f).
- A. Per ADDENDUM AA, CPT codes 63685 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 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 \$11,446.48 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 \$20,603.15. As a result, the difference between the MAR and amount paid of \$926.29 is recommended.

8. Per ADDENDUM AA, CPT codes 63650 is a device intensive procedure. Reimbursement is calculated per 28 Texas Administrative Code §134.402(f)(2)(A)(i)(ii).

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 $\$2,297.32 \times 0.9590 = \$2,203.12$.

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 $\$1,334.57 \times 235\% = \$3,136.23$.

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. The insurance carrier paid \$6,291.52. As a result, the difference between the MAR and amount paid of \$10.58 is recommended.

The requestor billed for 2 units; therefore, $\$10.58 \times 2 = \21.16 .

*The offset percentage for 2018 is found on the [CMS Hospital Outpatient PPS](#) page. Click on [Annual Policy Files](#) on the left hand side of the page, then go to 2018. Click on *2018 OPPS HCPCS Device Offset File* to access to the Final CY 2018 Device offsets.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$947.45.

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 \$947.45, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

06/24/2019

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.