



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 PLANO

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-19-5189-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

AUGUST 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2019 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: \$2,207.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The review determined that the provider is not due additional money."

Response Submitted by: ESIS.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2019	Ambulatory Surgical Care Services CPT Code 63650 (X2)	\$2,207.12	\$135.56

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

- 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 148-This procedure on this date was previously reviewed.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 18—Duplicate claim/service.
- CIQ378-This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on March 4, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$2,207.12 for ASC services rendered to the injured worker on March 4, 2019.
2. The insurance carrier paid \$12,433.48 for the disputed services based upon the fee guideline.
3. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.
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.

The disputed service is defined as:

- 63650- Percutaneous implantation of neurostimulator electrode array, epidural.

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.

Per ADDENDUM AA, CPT code 63650 is classified as device intensive procedures.

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."
7. To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.402(f)(2)(A)(i)(ii) that 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 63650 for CY 2019 = \$5,979.53.

The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 63650 for CY 2019 is 50.80%

Multiply these two = \$3,037.60

- Step 2 calculating the service portion of the procedure:

Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 63650 for CY 2019 is \$4,449.98.

This number is divided by 2 = \$2,224.99.

This number multiplied by the City Wage Index for Plano, TX of 0.9862 = \$2,194.28.

The sum of these two is the geographically adjusted Medicare ASC reimbursement = \$4,419.27.

The service portion is found by taking the geographically adjusted rate of \$4,419.27 minus the device portion of \$3,037.60 = \$1,381.67.

Multiply this number by the DWC payment adjustment of 235% = \$3,246.92.

Step 3 the MAR is determined by adding the sum of the reimbursement for the device portion + the service portion = \$6,284.52/each X 2 = \$12,569.04. The insurance carrier paid \$6,216.74/each X 2 = \$12,433.48. As a result, the requestis due the difference between MAR and paid of \$135.56.

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 \$135.56.

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 \$135.56, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

_____	_____	08/29/2019
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.