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 PLANO PARK

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-20-2515-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 17, 2020

REQUESTOR'S POSITION SUMMARY

"At this time we are requesting that this claim paid in accordance with the 2020 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $1,019.04

RESPONDENT'S POSITION SUMMARY

"The Carrier has reviewed the documentation and determined the Provider was properly reimbursed. This reimbursement represents the proper MAR for the global procedure under the Division's medical fee guideline."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 29888-RT	$1,019.04	$186.21

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
   - 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.
   - 170-Reimbursement is based on the outpatient/inpatient fee schedule.

Issues

Is the requestor due additional reimbursement for ASC services rendered on December 6, 2019?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $1,019.04 for ASC services rendered on December 6, 2019.

The fee guideline for ASC services is found at 28 TAC §134.402.

The requestor did not seek separate reimbursement for the implantables; therefore, 28 TAC §134.402 (f)(2)(A)(i)(ii) applies to this dispute.

28 TAC §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.

CPT Code 29888:

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 29888 for CY 2019 = $5,699.59

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25390 for CY 2019 is 34.45%

  Multiply these two = $1,963.51

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 29888 for CY 2019 is $3,696.68.
  This number is divided by 2 = $1,848.34.
  This number multiplied by the City Wage Index for Plano, Texas of 0.9862 = $1,822.83.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,671.17.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,707.66.

Multiply the service portion by the DWC payment adjustment of 235% = $4,013.01.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $5,976.52.

The total due for the ASC services rendered on December 6, 2019 is $5,976.52. The respondent paid $5,790.31. The requestor is due the difference between MAR and amount paid of $186.21.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $186.21.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $186.21, 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	07/17/2020 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 with the DWC. **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.