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 OF PLANO

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2709-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 15, 2020

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: $1,103.56

RESPONDENT'S POSITION SUMMARY

"The bill for DOS 12/17/19 has been reviewed an no additional payment is due as the bill was priced correctly."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 63650	$1,103.56	$67.80

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

codes:

- 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 963-Charge for this procedure exceeds Medicare ASC schedule allowance.
- W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor due additional reimbursement for CPT Code 63650 rendered on December 17, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,103.56 for CPT Code 63650 rendered on December 17, 2019.
2. The fee guideline for ASC services is found at 28 TAC §134.402.
3. Per ADDENDUM AA, CPT codes 63650 is a device intensive procedure. The requestor sought separate reimbursement for the implantables; therefore, 28 TAC §134.402(f)(2)(B)(i)(ii) applies to this dispute.

   28 TAC §134.402(f)(2)(B)(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: If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; 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 27427 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 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, Texas 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 minus the device portion = $1,381.67.

     Multiply the service portion by the DWC payment adjustment of 235% = $3,246.94.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $6,284.54.

The DWC finds the MAR for CPT code 63650 is $56,284.54. The respondent paid $6,216.74. The requestor is due the difference of MAR and paid of $67.80.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $67.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $67.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		08/12/2020
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 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.