



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

HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number

M4-21-0089-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

SEPTEMBER 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: \$524.05

RESPONDENT'S POSITION SUMMARY

"The service in dispute was processed and reimbursed in accordance with the Texas Fee Schedule and Guidelines, 28 TAC 134.402."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 30, 2020, Ambulatory Surgical Care Services (ASC) CPT Code 62323, \$524.05, \$522.39

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 §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. 28 TAC §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.
4. 28 TAC §133.10, effective April 1, 2014, sets out the healthcare provider billing procedures.

5. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment codes:
- P12-Workers' compensation jurisdictional fee schedule adjustment.
  - 4063-Reimbursed is based on the physician fee schedule when a professional service was performed in the facility setting.
  - 4480-Recommended allowance has been authorized by the payor
  - 1115-We find the original review to be accurate and are unable to recommend any additional allowance.
  - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on June 30, 2020?

### Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$524.05 for ASC services rendered on June 30, 2020.
2. The respondent contends that reimbursement of \$208.75 was made per the fee guideline.
3. The fee guidelines for disputed services is found in 28 TAC §134.402.

Per ADDENDUM AA, CPT codes 62323 is a device intensive procedure.

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."

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 62323 for CY 2020 = \$625.05

The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 62323 for CY 2020 is 0.20%

Multiply these two = \$1.25

- Step 2 calculating the service portion of the procedure:

Per Addendum AA, the Medicare ASC reimbursement rate for code 62323 for CY 2020 is \$315.83.

This number is divided by 2 = \$157.92.

This number multiplied by the City Wage Index for Plano, Texas of 0.9747 = \$153.92.

The sum of these two is the geographically adjusted Medicare ASC reimbursement = \$311.84.

The service portion is found by taking the geographically adjusted rate minus the device portion = \$310.59.

Multiply the service portion by the DWC payment adjustment of 235% = \$729.89.

- Step 3 calculating the MAR:

The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = \$731.14.

The DWC finds the MAR for CPT code 62323 is \$731.14. The respondent paid \$208.75. The DWC finds the requestor is due additional reimbursement of \$522.39.

### **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 \$522.39.

### ***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 \$522.39, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

### **Authorized Signature**

_____	_____	10/12/2020
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 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 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**