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
WATER LEAF SURGERY CENTER

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-21-0698-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
DECEMBER 21, 2020

REQUESTOR'S POSITION SUMMARY

"We would like to request a reconsideration of our claim for the following reason; the amount allowed/paid on CPT 64510, is less than the Medicare allowable of $397.93, when performed at an ASC."

Amount in Dispute: $2,316.27

RESPONDENT'S POSITION SUMMARY

"The Provider alleges they are entitled to $935.13 as ASC reimbursement, however, the Provider billed for professional services on a HCFA-1500. Consequently, they were reimbursed for the professional fee component they billed, not the facility fee component which would have been billed on a UB-04 form. As such, the Provider has been properly reimbursed under the professional services fee schedule as they billed the procedures."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2020 May 15, 2020 May 29, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 64510	$722.09/ea X 3 = $2,316.27	$2,316.27

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. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
   - 863-Reimbursement is based on the applicable reimbursement fee schedule.
   - 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.
   - 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.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered from April 30, 2020 through May 29, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,316.27 for ASC services rendered from April 30, 2020 through May 29, 2020.
2. The respondent contends that reimbursement of $489.12 was made per the fee guideline.
3. The fee guidelines for disputed services is found in 28 TAC §134.402.

   28 TAC §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.

   28 TAC §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.

   The respondent wrote, "The Provider alleges they are entitled to $935.13 as ASC reimbursement, however, the Provider billed for professional services on a HCFA-1500." The DWC finds that CMS requires ASC services to be billed on the CMS 1500's form; therefore, the respondent's argument is not supported.

4. To determine the appropriate reimbursement for CPT code 64510 the DWC refers to 28 TAC §134.402(f).

   A. Per ADDENDUM AA, CPT code 64510 is a non-device intensive procedure.

   28 TAC §134.402(f)(1)(A) 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:

(1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 64510 CY 2020 is $410.32.

The Medicare ASC reimbursement is divided by 2 = $205.16.

This number multiplied by the City Wage Index for Austin, Texas of 0.9396= $192.77.

Add these two together = $397.93.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $935.13.

The DWC finds the MAR for CPT code 64510 is $935.13. The requestor billed for three (3) dates; therefore, $935.13 X 3 = $2,805.39. The respondent paid $489.12. The requestor is due the difference between the MAR and amount paid of $2,316.27.

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 $2,316.27.

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 $2,316.27, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

		02/02/2021
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.