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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CALLOWAY CREEK SURGERY CENTER

Respondent Name
STARR INDEMNITY & LIABILITY CO.

MFDR Tracking Number
M4-21-0877-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 29, 2021

REQUESTOR'S POSITION SUMMARY

The Correct TWC ASC Allowable when Facility is requesting separate payment for implants = $11,441.67."

Amount in Dispute: $174.94

RESPONDENT'S POSITION SUMMARY

"Enclosed please find a detailed chart which shows the calculation of the billed procedures as a whold. The chart concludes Reuestor should have been paid $11,441.67. However, Requestor was paid $12,563.24…no additional reimbursement is due."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 29827	$108.07	$108.07
	ASC for CPT Code 29823	$26.59	$26.58
	ASC for CPT Code 29824	$26.59	$26.58
	ASC for CPT Code 64415	$13.69	$13.69
TOTAL		$174.94	$174.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 a

medical fee dispute.

2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Per the submitted explanation of benefits, the services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 5283-Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or car
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on January 29, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $174.94 for ASC services rendered to the injured worker on January 29, 2020.
2. 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.

To determine the appropriate reimbursement for non-device intensive procedure CPT codes 29827, 29823, 29824 and 64415, the DWC refers to 28 TAC §134.402(f)(1)(B).

28 TAC §134.402(f)(1)(B) 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: B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-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 Medicare ASC facility reimbursement amount multiplied by 153 percent.

The following formula was used to calculate the MAR: Multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153%.

The DWC finds the following:

Code	Medicare Participating Amount for North Richland Hills, Texas	MAR (Principal Procedure paid at 100% and Secondary Procedures paid at 50%)	Insurance Carrier Paid	Amount Due
29827	$2,774.21	$4,244.53	$4,136.46	$108.07
29823	$1,272.88	$1947.51 X 50% = $973.75	$947.17	$26.58
29824	$1,272.88	$1947.51 X 50% = $973.75	$947.17	$26.58
64415	$406.05	$621.23 X 50% = $310.63	$296.94	$13.69

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 $174.92.

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 $174.92 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/04/2021 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 TAC §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 MDR 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 TAC §141.1(d).

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