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 AT BLUE STAR

Respondent Name
FRISCO ISD

MFDR Tracking Number
M4-21-1554-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
MAY 3, 2021

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: $532.11

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 64446	$476.02	$0.00
	ASC Services for CPT Code 64447	$56.09	
TOTAL		$532.11	$0.00

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 February 22, 2021, 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:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee schedule.
   - 236-This procedure or procedure modifier combination is not compatible with another procedure or procedure modifier combination provided on the same day according to the NCCI or workers' compensation state regulations fee schedule requirements.
   - 435-Per NCCI Edits, the value of this procedure is included in the value of the comprehensive procedure.
   - 350-This bill has been identified as a request for reconsideration or appeal.
   - W3-IN accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to reimbursement for ASC services related to CPT codes 64446 and 64447 rendered on August 28, 2020?

Findings

1. The Austin carrier representative for Frisco ISD is Downs Stanford PC. Downs Stanford PC received notice of this medical fee dispute on May 11, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution in the amount of $532.11 for ASC services related to CPT codes 64446 and 64447 rendered on August 28, 2020.

3. The respondent contends that the allowance of CPT codes 64446 and 64447 are included in the allowance of code 27650 rendered on August 28, 2020.

   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. (6) "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.

   28 TAC §134.402(f) 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.

A review of the submitted medical reports do not support billed service or a separate service from code 27650. The DWC finds per CCI edits, CPT codes 64446 and 64447 are components of CPT code 27650; therefore, the respondent's denial of payment is supported.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/30/2021
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.