



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

BAYLOR SURGICARE AT PLANO PARK

Respondent Name

TRAVELERS INDEMNITY CO

MFDR Tracking Number

M4-21-1590-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

MAY 7, 2021

REQUESTOR'S POSITION SUMMARY

"At this time we are requesting that this claim paid in accordance with the 2021 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: \$3,018.12

RESPONDENT'S POSITION SUMMARY

"...the Provider has been properly reimbursed under the applicable fee schedule for the disputed services. The Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 23, 2021	Ambulatory Surgical Care Services (ASC) CPT Code 27726	\$3,018.12	\$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

- 28 Texas Administrative Code §133.307, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.

- 4063-Reimbursement based on the physician fee schedule when a professional service was performed in a facility setting.
- 00663-Reimbursement has been calculated according to state fee schedule guidelines.
- 193, 00563-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 related to CPT code 27726 rendered on February 23, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$3,018.12 for ASC services related to CPT code 27726 rendered on February 23, 2021.
2. The respondent contends that no additional reimbursement is due because payment of \$6,168.78 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.

4. Per ADDENDUM AA, CPT code 27726 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 27726 for CY 2021 = \$6,264.95.

The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 27726 for CY 2021 is 37.92%

Multiply these two = \$2,375.67

- Step 2 calculating the service portion of the procedure:
 Per Addendum AA, the Medicare ASC reimbursement rate for code 27726 for CY 2021 is \$3,960.01.
 This number is divided by 2 = \$1,980.00.
 This number multiplied by the City Wage Index for Plano, Texas of 0.9744 = \$1,929.32.
 The sum of these two is the geographically adjusted Medicare ASC reimbursement = \$3,909.32.
 The service portion is found by taking the geographically adjusted rate minus the device portion = \$1,533.65.
 Multiply the service portion by the DWC payment adjustment of 235% = 3,604.07.
- Step 3 calculating the MAR:
 The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = \$5,979.74.

The DWC finds the MAR for CPT code 27726 is \$5,979.74. The respondent paid \$6,168.78. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional 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 DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		06/01/2021
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.