TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgicare of Plano

Respondent Name
City of Plano

MFDR Tracking Number
M4-21-2219

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 2, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 62323	$530.71	$530.71
	Total	$530.71	$530.71

Requestor's Position

"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: $530.71

Respondent's Position

"The self-insured has reimbursed the provider in the amount of $213.23 and we believe that this is based upon the medical fee guideline."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307, sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.402, sets out the fee guidelines for ASC services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- W3-In accordance with rule 34.804, this bill has been identified as a request for reconsideration or appeal.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the requestor entitled to additional reimbursement for ASC services rendered on May 3, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,760.80 for ASC services rendered on April 22, 2021.

   The respondent contends that reimbursement of $213.23 was made per the fee guideline.

   Per ADDENDUM AA, CPT code 62323 is a non-device intensive procedure.

   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: 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 62323 CY 2021 is $320.67

The Medicare ASC reimbursement is divided by 2 = $160.34.

This number multiplied by the City Wage Index for Plano, Texas of 0.9744= $156.23.

Add these two together = $316.57.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $743.94.

The DWC finds the MAR for CPT code 62323 is $743.94. The respondent paid $213.23. The difference between MAR and amount paid is $530.71. The DWC finds the requestor is due additional reimbursement of $530.71.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $530.71 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that City of Plano must remit to Baylor Surgicare of Plano $530.71 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/16/2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.