TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgicare of Plano

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-22-0285-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 13, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 29, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 62323	$743.94	$0.00
	ASC CPT Code 62273	$0.00	$0.00
	Total	$374.96	$0.00

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: $374.96

Respondent's Position

The Austin carrier representative for Texas Mutual Insurance Co. is Texas Mutual Insurance Co. Texas Mutual Insurance Co. received a copy of this medical fee dispute on October 19, 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).

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 or denied] the payment for the disputed services with the following claim adjustment codes:

- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- CAC-236-This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers' compensation state regulations/fee schedule requirements.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- DC4-No additional reimbursement allowed after reconsideration.
- 763-Paid per ASC FG at 235%; implants not applicable or separate reimbursement (w/signed cert) not requested: Rule 134.402(G).
- 435-Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.

Issues

1. Is Texas Mutual Insurance Company's denial of CPT code 62273 based upon unbundling supported?
2. Is Baylor Surgicare of Plano entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $374.96 for ASC services rendered on June 29, 2021.

   The respondent denied reimbursement for CPT code 62273 based upon reason codes "435," and "CAC-236."

   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.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."

   Per CMS National Correct Coding Initiative Edits, Procedure-to-Procedure edits, CPT code 62323 is unbundled to code 62273 and a modifier is not allowed to differentiate the service; therefore, the respondent's denial is supported.

2. The respondent paid $743.93 for CPT code 62273

   Per Addendum AA, CPT code 62273 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 62273 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% = $743.93.

The DWC finds the MAR for the ASC services rendered on June 29, 2021 is $743.93. The

respondent paid $743.93. As a result, additional reimbursement is not recommended.

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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/26/2022 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.