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 at Mansield

Respondent Name
Arch Indemnity Insurance Co.

MFDR Tracking Number
M4-22-0474-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 4, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 18, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 24715	$12,422.05	$0.00
	ASC CPT Code 0232T	$0.00	$0.00
	Total	$12,422.05	$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: $12,422.05

Respondent's Position

"It is the carrier's position that the reimbursement amount pursuant to the Medical Fee Guideline is $11,083.54. The provider is not entitled to any additional reimbursement."

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:

- 4097-Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider's charge.
- 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
- 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- P12-Workers' compensation jurisdictional fee schedule adjustment.

1. Is Baylor Surgicare at Mansfield entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $12,422.05 for ASC services rendered on August 18, 2021.

   The respondent contends that additional reimbursement is not due because payment of $11,083.54 was made per the fee guideline.

   The fee guidelines for disputed services is found in 28 TAC §134.402.

   Per Addendum AA, CPT code 24715 is not listed as an ASC Covered Surgical Procedures for CY 2021.

   28 TAC §134.402(i) states,

   > If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:
   > (1) The agreement may occur before, or during, preauthorization.
   > (2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.
   > (3) The agreement between the insurance carrier and the ASC must be in writing, in

clearly stated terms, and include:

(A) the reimbursement amount;

(B) any other provisions of the agreement; and

(C) names, titles and signatures of both parties with dates.

(4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

The requestor did not submit any documentation that an agreement was reached prior or during preauthorization for code 24715. The dispute packet did not contain a signed copy of an agreement, that identified the parties to the agreement, or the amount of reimbursement as required by 28 TAC §134.402(i) for code 24715. 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 entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/07/2021 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.