

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Metrocrest Surgery Center, LP

Respondent Name

Standard Fire Insurance Co.

MFDR Tracking Number

M4-22-0680-01

Carrier's Austin Representative

Box Number 05

DWC Date Received

December 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 29, 2021	Ambulatory Surgical Care Services CPT Code 28485	\$3,000.78	\$73.60

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: \$3,000.78

Respondent's Position

"The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

Response Submitted by: Travelers

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:

- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal
- 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 170 – Reimbursement is based on the outpatient/inpatient fee schedule.

Issues

1. Is Metrocrest Surgery Center, LP entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$3,000.78 for ASC services rendered on July 29, 2021.

The respondent contends that additional reimbursement is not due because payment of \$6,154.84 was made per the fee guideline.

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

A. Per Addendum AA, CPT codes 28485 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 28485 for CY 2021 = \$6,264.95.

The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 28485 for CY 2021 is 34.61%

Multiply these two = **\$2,168.30**.

- Step 2 calculating the service portion of the procedure:

Per Addendum AA, the Medicare ASC reimbursement rate for code 28485 for CY 2021 is \$3,946.53.

This number is divided by 2 = \$1,973.27.

This number multiplied by the City Wage Index for Carrollton, Texas of 0.9744 = \$1,922.75.

The sum of these two is the geographically adjusted Medicare ASC reimbursement = \$3,896.02.

The service portion is found by taking the geographically adjusted rate minus the device portion = \$1,727.72.

Multiply the service portion by the DWC payment adjustment of 235% = **\$4,060.14**.

- Step 3 calculating the MAR:

The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = **\$6,228.44**.

The DWC finds the MAR for the ASC services rendered on July 29, 2021, is \$6,228.44. The respondent paid \$6,154.84. The DWC finds the requestor is due additional reimbursement of **\$73.60**.

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 \$73.60 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 Standard Fire Insurance Co. must remit to Metrocrest Surgery Center, LP \$73.60 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

January 20, 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.