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
Physicians Surgical Center

Respondent Name
New Hampshire Insurance Co.

MFDR Tracking Number
M4-22-1345-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 13, 2021	ASC Services CPT Code 63650	$4,134.34	$123.94
October 13, 2021	ASC Services CPT Code 63650-59	$4,134.34	$123.94
October 13, 2021	HCPCS C1897	$0.00	$0.00
	Total	$8,268.67	$247.88

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: $8,268.67

Respondent's Position

The carrier's initial EOB recommended reimbursement of $12,436.52 This was based upon the reimbursement of $6,218.26 for CPT code 63650 and another $6,218.26 for CPT code 63650 with a 59 modifier.

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 ambulatory surgical center services.

Denial Reasons

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

- P12
- B13
- 4915 – The charge for the services represented by the code is included bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded form payment.
- 4123 – Allowance is based on Texas ASC device procedure calculation and guidelines.
- 983 – Charge for this procedure exceeds medicare ASC Schedule allowance
- 86 – Service performed was distinct or independent from other services performed on the same day.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is Physicians Surgical Center entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $8,268.67 for ASC services rendered on October 13, 2021.

   The respondent contends that additional reimbursement is not due because payment of $12,436.52 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 63650 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 63650 for CY 2021 = $6,160.68.

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 63650 for CY 2021 is 48.22%.

  Multiply these two = **$2,970.68**.

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 63650 for CY 2021 is $4,473.13.
  This number is divided by 2 = $2,236.57.
  This number multiplied by the City Wage Index for Fort Worth, Texas of 0.9697 = $2,168.80.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement = $4,405.37.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,434.69.

  Multiply the service portion by the DWC payment adjustment of 235% = **$3,371.52**.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = **$6,342.20**.

Procedure code 63650 was billed for two units and is not subject to the multiple procedure discount. The DWC finds the MAR for the ASC services rendered on October 13, 2021, is $12,684.40. The respondent paid $12,436.52. An additional reimbursement of **$247.88** is 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 established that additional reimbursement of $247.88 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 New Hampshire Insurance Co. must remit to Physicians Surgical Center $247.88 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 29, 2022
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 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, opción 3 o correo electronico CompConnection@tdi.texas.gov.