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

General Information

Requestor Name
Metrocrest Surgery Center

Respondent Name
Tri-State Insurance Company of Minnesota

MFDR Tracking Number
M4-22-1435-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 4, 2021	28485 T4	$3934.32	$1,007.09
October 4, 2021	76000 TC	$3.97	$0.00
October 4, 2021	C1713	$0.00	$0.00
	Total	$3938.29	$1,007.09

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: $3,938.29

Respondent's Position

The Austin carrier representative for Tri-State Insurance Company of Minnesota is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on March 22, 2021.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 centers.

3. 28 TAC 135.304 sets uut the reimbursement for radiological services.

Denial Reasons

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

- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 350 – Bill has been identified as a request for reconsideration or appeal
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 700 – This charge was reimbursed in accordance o the Texas Medical Fee Guideline
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' Compensation jurisdiction fee schedule adjustment

Issues

1. What rule applies for determining reimbursement for the disputed services?

2. Is the requester entitled to additional reimbursement?

Findings

2. DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center

Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.

DWC Rule 28 TAC §134.402 (f) states in pertinent part 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 published in the Federal Register. Reimbursement for device intensive procedures shall be the sum of the ASC device portion and the ASC service portion multiplied by 235 percent.

The following formula was used to calculate the MAR:

Procedure Code 28485 has a payment indicator of J8. This is a device intensive procedure paid at an adjusted rate. 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 applicable date of service is $6,264.95
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 28485 for applicable date of service 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 applicable date of service is $3,946.53.
- This number is divided by 2 = $1,973.26
- This number multiplied by the CBSA wage index for Carrollton Texas of 0.9744 = $1,922.74
- The sum of these two is the geographically adjusted Medicare ASC reimbursement = $1,973.26 + $1,922.74 = $3,896.00
- The service portion is found by taking the geographically adjusted rate minus the device portion = $3,896.00 - $2,168.30 = $1,727.70

- Multiply the service portion by the DWC payment adjustment of 235% = $1,727.70 x 235% = $4,060.09

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $2,168.30 + $4,060.09 = $6,228.39

Procedure Code76000 TC has a payment indicator of Z3 payment based on Medicare Physician Fee Schedule non-facility. DWC Rule 134.203 (c)(1) states in pertinent part to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

The established conversion factor for the applicable date of service annual conversion factor.

To calculate the MAR the DWC conversion factor is divided by the Medicare conversion factor then multiplied by the physician fee schedule amount or 61.17/34.8931 x $28.47 = $49.91.

3. The DWC finds the MAR for CPT code 28485 is $6,228.39. The respondent paid $5,221.30. Remaining balance of $1,007.09 is recommended.

   Procedure code 76000 TC has a MAR of $49.91. The respondent paid $60.00. No additional payment is due.

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 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. It is ordered that respondent must remit to requestor $$1,007.09 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 8, 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.