



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgicare at North
Dallas

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-22-1617-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

April 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 15, 2021	64774	\$0.00	\$0.00
September 15, 2021	64787	\$0.00	\$0.00
September 15, 2021	64721	\$607.73	\$933.44
September 15, 2021	C9353	\$2998.60	\$0.00
Total		\$2954.90	\$933.44

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."

Amount in Dispute: \$2954.90

Respondent's Position

The Austin carrier representative for Texas Mutual is Texas Mutual. The representative was notified of this medical fee dispute on April 5, 2022.

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 §133.305 sets out the general requirements of medial fee dispute.
3. 28 TAC §133.240 sets out the requirements of medical payments and denials.
4. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgical centers.

Denial Reasons

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

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment
- CAC-219 – Based on extent of injury
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- D25 – Approved non network provider for Workwell, TX network claimant per Rule 1305.53(C)
- 246 – The treatment/service has been determined to be unrelated to the extent of injury final adjudication has not taken place
- 763 – Paid per ASC FG at 235%: Implants not applicable or separate reimbursement (w/signed cert) not requested Rul3 134.402(G)

Issues

1. Is the insurance carriers denial supported?
2. What rule applies for determining reimbursement for the disputed services?

Findings

1. Documentation provided by the parties indicates that the insurance carrier denied payment to the requestor due to an unresolved extent-of-injury issue for code 64721. DWC Rule 28 Texas Administrative Code §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

Review of the documentation submitted by the parties finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the division finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 Texas Administrative Code §133.240.

Because the service in dispute does not contain an unresolved extent of injury issue, this matter is ripe for adjudication of a medical fee under 28 Texas Administrative Code §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

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.

Procedure Code 64721 has a payment indicator of A2. DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part reimbursement for non-device intensive procedures shall be 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 64721 for applicable date of service is \$804.72
- The Medicare ASC reimbursement is divided by 2 = $\$804.72/2 = \402.36 .
- This number multiplied by the City Wage Index for Dallas, Texas of 0.9744 = \$392.06.
- Add these two together = \$794.42.
- To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = \$1,866.89 reduced by 50% is \$933.44.

DWC Rule 28 TAC §134.402 (g) A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable.

(1) The facility or surgical implant provider requesting reimbursement for the implantable shall:

- (A) bill for the implantable on the Medicare-specific billing form for ASCs;
- (B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled.

Review of the submitted documentation included with the request for MFDR found the submitted invoice was for Nerve Protector D=10MM L=40MM.

Review of the submitted operative report indicates a 7 mm x 40 mm nerve wrap was used. The cost of the implant billed as Code C9353 is not supported. No additional payment 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 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 Texas Mutual must remit to Baylor Surgicare North Dallas \$933.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	July 20, 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 electrónico CompConnection@tdi.texas.gov.