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 of Plano

Respondent Name
Old Republic General Insurance Corp

MFDR Tracking Number
M4-22-1812-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
April 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 21 2021	62321	$743.94	$733.81
September 21 2021	20552	$0.00	$0.00
	Total	$743.94	$733.81

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: $743.94

Respondent's Position

"After re-evaluation of the system denial, documentation submitted and the topic information; Our CV team would uphold the system denial. 62321 includes image guidance and the use of image guidance is not supported. For additional allowance, the provider must re-submit with a copy of the image, a statement that permanent image was stored for the record of a statement that the fluoroscopy machine that was used does not have the capability to store permanent images."

Response Submitted by: Gallagher Bassett

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.

Denial Reasons

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

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule/adjustment
- 851 – the allowance was adjusted in accordance with multiple procedure rules and/or guidelines
- 247 – A payment or denial has already been recommended for this service
- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600

Issues

1. Did the insurance carrier raise a new issue?
2. What rule applies for determining reimbursement for the disputed services?
3. Is the requester entitled to additional reimbursement?

Findings

1. DWC Rule 28 TAC §133 (d)(2)(F) states in pertinent part the response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. In their position statement the insurance carrier states, "62321

includes image guidance and the use of image guidance is not supported." The previous denials presented to both parties did not include lack of documentation or service not supported. This position will not be considered in this review.

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.

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 as in annual Addendum AA, ASC covered surgical procedures publication of the Federal Register.

Reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent when separate implant reimbursement is not requested.

The following formula was used to calculate the MAR:

- The Medicare ASC reimbursement for code 62321 for applicable date of service is $320.67.
- The Medicare ASC reimbursement is divided by 2 = $160.33.
- This number multiplied by the CBSA wage index for Austin, Texas of 0.9476= $151.93.
- Add these two together = $312.26.
- To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $733.81.

The DWC finds the MAR for CPT code 62321 is $733.81. This amount 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 $733.81 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 Old Republic General Insurance Corp must remit to Baylor Surgicare $733.81 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

______________________	______________________	June 14, 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.