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
Texas Surgical Center

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-22-1817-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 31, 2022	29806	$54.71	$0.00
January 31, 2022	64415	$3.25	$0.00
January 31, 2022	C1713	$0.00	$0.00
	Total	$57.96	$0.00

Requestor's Position

"At this time we are requesting that this claim paid in accordance with the 2022 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $57.96

Respondent's Position

"We are attaching a copy of the Carrier's EOR dated February 15, 2022 that recommended reimbursement under CPT code 29805 in the amount of $6,476.06 and under CPT code 64415 in the amount of $460.05. 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 centers.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 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
- P13 – Payment reduced or denied based on Workers' Compensation jurisdictional regulations or payment policies
- W3 – Bill is a reconsideration or appeal

Issues

1. Is the insurance carriers' reduction supported?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for surgery rendered in January 2022 in an ambulatory surgical center. The insurance carrier reduced the services based on DWC fee 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.

   Procedure code 29806 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 29806 for applicable date of service is $2,998.15
   - The Medicare ASC reimbursement is divided by 2 = $1,499.07.
   - This number multiplied by the CBSA for Midland, Texas of 0.8366 = $1,254.13
   - Add these two together = $2,753.20
   - To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $6,470.02

   Procedure Code 63415 has a payment indicator of A2 and is subject to multiple procedure discounting. 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 64415 for applicable date of service is $425.96
   - The Medicare ASC reimbursement is divided by 2 = $212.98.
   - This number multiplied by the CBSA for Midland, Texas of 0.8366 = $178.18
   - Add these two together = $391.16.
   - To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $919.23 reduced by 50% is $459.61.

3. The DWC finds the MAR for CPT code 29806 is $6,470.02. The respondent paid $6,476.06. No additional payment is recommended. Procedure code 64415 has a MAR of $459.61. The

respondent paid $460.05. 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 not 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.

Authorized Signature

		August 5, , 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.