Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgicare at Mansfield

Respondent Name
California Insurance Company

MFDR Tracking Number
M4-22-1830-01

Carrier's Austin Representative
Box Number 12

DWC Date Received
April 26, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 21, 2021	24366	$8901.46	$253.61
June 21, 2021	C1766	$0.00	$0.00
June 21, 2021	L8699	$0.00	$0.00
	Total	$8901.46	$253.61

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: $8,901.46

Respondent's Position

"In this case, the original recommendation for CPT 24366 in the amount of $4,792.90 is the ASC service portion multiplied by 235%, in accordance with Division Rule 134.402(f)(2)(ii). Therefore, no additional reimbursement is warranted for these services."

Response submitted by: California Insurance Company

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:

- 29 – Services not identified in the operative report
- 89 – Device-intensive procedure added to ASC list in 2008 or later; paid at adjusted rate
- NSIB12 – Services not documented in patients medical record
- NSIP12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. What rule applies for determining reimbursement for the disputed services?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of Code 24366 as part of services rendered in June 2021. The insurance carrier reduced the allowed amounts based on the workers compensation fee guidelines. Review of the applicable fee guideline is found below.

   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 when separate reimbursement of implants is requested shall be the sum of the lesser of the manufacturer's invoice amount or the net amount plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission and the ASC service portion multiplied b7 235 percent.

The following formula was used to calculate the MAR:

Procedure Code 24366 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 24366 for disputed date of services = $12,314.76
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for Code 24366 or disputed date of service is 55.42%
- Multiply these two = $12,314.76 x 55.42% = $6,824.84

Step 2 calculating the **service portion** of the procedure:

- Per Addendum AA, the Medicare ASC reimbursement rate for code 24366 for disputed date of service is $9,088.25.
- This number is divided by 2 = $4,544.12
- This number multiplied by the CBSA Wage Index for Mansfield, Texas of 0.9744 = $4,427.79.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$4,544.12 + $4,427.79 = $8,971.91
- The service portion is found by taking the geographically adjusted rate

minus the device portion = $8,971.91 - $6,824.84 = $2,147.07

- Multiply the service portion by the DWC payment adjustment of 235% = $5,045.61.

2. The amount paid for the implants used in the surgery are not in dispute. The DWC finds the MAR for CPT code 24366 is $5,045.61. The respondent paid $4,792.90 the remaining balance of $253.61 is due to the requestor.

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 California Insurance Co must remit to Baylor Surgicare at Mansfield $253.61 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 2, 2022 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.