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
Highlands Insurance Co

MFDR Tracking Number
M4-22-1859-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
April 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 30, 2021	63685	$14429.38	$1,089.16
December 30, 2021	C1820	$19000.00	$0.00
December 30, 2021	C1787	$1100.00	$0.00
	Total	$34,529.38	$1,089.16

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: $34,529.38

Respondent's Position

"Please be advised that upon review of the billing for date of service December 30, 2021, no additional payment is due as the bill was priced correctly and paid pursuant to the fee guideline."

Response submitted by: Ayers & Ayers

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:

- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 197 – Payment denied/reduced for absence of precertification/authorization
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – Bill is a reconsideration or appeal
- 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical. Please expect a detailed explanation of review for surgical implant charges directly from ForeSight Medical
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies

Issues

1. Did the requestor request separate reimbursement for implants per applicable DWC rules?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for a surgical procedure rendered on December 30, 201 in an ambulatory surgical center and the implants utilized in the surgery. The insurance company reduced the payment of the surgery (Code 63885) based on the workers' compensation fee schedule and denied the codes C1820 and C1787 based on workers' compensation payment polices.

   DWC Rule §133.10(f)(1)(W) details what supplemental information is required when separate reimbursement for surgically implanted devices is requested.

   Review of the submitted medical bill found no request was indicated as required by Rule 133.10(f)(1)(W). No separate reimbursement is recommended.

   The applicable fee guideline for device intensive procedure 63685 without implants is shown below.

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(e)(2) states in pertinent part, regardless of billed amount, reimbursement if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including reimbursement for implantables when applicable. Separate reimbursement for the implants was not requested per applicable Division rules.

   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 63685 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 CMS Hospital Outpatient Prospective Payment System (OPPS) code 63685 for applicable date of service is $29,444.52.
- The device dependent APC offset percentage for CMS OPPS found in Addendum P for code 63685 is 82.22%.
- Multiply these two = $29,444.52 x 82.22% = $24,209.28.

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

- Per Addendum AA, the Medicare ASC reimbursement rate for code 63685 for applicable date of service is $23,894.02.
- This number is divided by 2 = $23,894.02/2 = $11,947.01
- This number multiplied by the CBSA Index for Carrolton, Texas of 0.9744 = $11,947.01 x 0.9744 = $11,641.17
- The sum of these two is the geographically adjusted Medicare ASC reimbursement = $11,947.01 + $11,641.17 = $23,588.18
- The service portion is found by taking the geographically adjusted rate minus the device portion = $23,588.18 – $24,209.28 = (**-621.10**)
- Multiply the service portion by the DWC payment adjustment of 235%. (**-621.10)** x 235% = **(-1,459.58)**.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $24,209.28 + (**-1,459.58**) = $22,749.70.

3. The DWC finds the MAR for CPT code 63685 is $22,749.70. The respondent paid $21,660.54. The remaining balance of $1,089.16 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 respondent must remit to requestor $1,089.16 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 22 , 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.