TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Comfort Surgery Center of San Antonio

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-2060-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 16, 2022

Summary of Findings

Jun

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 2, 2021	63650-RT	$3563.88	$0.00
June 2, 2021	63650-LT	$3563.88	$0.00
June 2, 2021	76000-TC	$39.02	$0.00
June 2, 2021	L8682 x 32	$0.00	$0.00
	Total	$7166.78	$0.00

Requestor's Position

"Due to the incorrectly applied multiple procedure guidelines, our facility has been underpaid by a significant amount."

Amount in Dispute: $7166.78

Respondent's Position

"Review of the audit confirms that payment was made per Device Intensive Method and included the payment for the device portion, which was an oversight from the carrier, based on the fact the facility requested separate reimbursement for implants. When the provider request separate reimbursement for implants on device intensive procedure, the device portion is not paid since the provider is require to submit invoice for cost of implants. Upon review of the appeal, the

facility did not include signed certification and/or manufacturers invoice for cost of implants, no additional payment was made on appeal. This bill was processed in accordance with ASC Rule 134.402, no additional payment is due."

Response submitted by: Texas Mutual

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or workers compensation state regulations/fee schedule requirements
- D25 – Approved non network provider for Workwell, TX network claimant per Rule 1305.153(c).
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
- 763 – Paid per ASC FG at 235%; Implants not applicable or separate reimbursement (w/signed cert) not requested. (Rule 134.402(G)
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

Issues

1. Is the insurance carriers' denial supported?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier denied code 76000 based on the Medicare NCCI edits. Review of the applicable NCCI edits for the date of service finds an edit does exist and separate payment is not recommended. The other services in dispute code 63650 RT, LT was not reduced based on multiple procedure discounting as stated by the requestor but was calculated based on worker's compensation fee guidelines and Medicare payment policies. These polices and calculation are 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 (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 63650-RT 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 Outpatient Prospective Payment System (OPPS) code 63650 for applicable date of service is $6,160.68.
   - The device dependent APC offset percentage for CMS OPPS found in Addendum P for code 63650 for applicable date of service is 48.22%.
   - Multiply these two = $2,970.68

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

- Per Addendum AA, the Medicare ASC reimbursement rate for 63650 for applicable date of service is $4,473.13.
- This number is divided by 2 = $2,236.56.
- This number multiplied by the CBSA Index for San Antonio, Texas of 0.8496 = $1,900.18.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$2,236.56 + $1,900.18 = $4,136.74
- The service portion is found by taking the geographically adjusted rate minus the device portion = $4,136.74 – $2,970.68 = $1,166.06
- Multiply the service portion by the DWC payment adjustment of 235% = $1,166.06 x 235% = $2,740.24.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $2,970.68 + $2,740.24 = $5,710.92.

Procedure Code 63650-LT 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 Outpatient Prospective Payment System (OPPS) code 63650 for applicable date of service is $6,160.68.
- The device dependent APC offset percentage for CMS OPPS found in Addendum P for code 63650 for applicable date of service is 48.22%.
- Multiply these two = $2,970.68

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

- Per Addendum AA, the Medicare ASC reimbursement rate for 63650 for applicable date of service is $4,473.13.
- This number is divided by 2 = $2,236.56.
- This number multiplied by the CBSA Index for San Antonio, Texas of 0.8496 = $1,900.18.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$2,236.56 + $1,900.18 = $4,136.74

- The service portion is found by taking the geographically adjusted rate minus the device portion = $4,136.74 – $2,970.68 = $1,166.06
- Multiply the service portion by the DWC payment adjustment of 235% = $1,166.06 x 235% = $2,740.24.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $2,970.68 + $2,740.24 = $5,710.92

3. The DWC finds the MAR for CPT code 63650-RT is $5,7110.92. The MAR for code 63650-LT is $5,710.92. For a total of $11,422,85. The respondent paid $11,450.86. This amount includes a separate payment for the implants. 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

		June 24, 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.