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
Cypresswood Surgery Center

Respondent Name
Truck Insurance Exchange

MFDR Tracking Number
M4-23-3298-01

Carrier's Austin Representative
Box Number 14

DWC Date Received
August 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 23, 2023	63685	$4,268.81	$0.00
	Total	$4,268.81	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. The did submit a copy of their reconsideration that states, "We have multiple claims priced by IMO and none of them are paid correctly. Below are the calculations according to the Texas Work Comp Fee Schedule for Cypresswood's local."

Amount in Dispute: $4,268.81

Respondent's Position

"After reviewing the documentation provided the bill was reviewed per Centers for Medicaid and Medicare (CMS) methodology and determined that no additional allowance is due to the provider."

Response submitted by: Mitchell

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 surgery services.

Denial Reasons

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

- 350 – Bill has been identified as a request for reconsideration or appeal.
- 618 – The value for this procedure is packaged into the payment of other services performed on the same day.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guidelines.
- 95 – Plan procedures not followed.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- U00 – There was no UR procedure treatment request received.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration.

Issues

1. Are the insurance carrier's denials supported?

2. Is additional reimbursement due to the requestor?

Findings

1. The requestor is seeking additional payment of ambulatory surgical services rendered in February of 2023. The insurance carrier reduced the charges based on packaging and fee guidelines. The calculation of the maximum allowable reimbursement (MAR) per applicable Division fee guidelines is found 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 62385 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 Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 63685 for applicable date of service is $29,358.48.
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 63685 for applicable date of service is 81.83%.
- Multiply these two = $24,024.04

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 $24,716.49.
- This number is divided by 2 = $12,358.24.
- This number multiplied by the CBSA for Houston, Texas. 0.9994 x $12,358.24 = $12,350.82.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$12,358.24 + 12,350.82 = 24,709.06.
- The service portion is found by taking the geographically adjusted rate minus the device portion = $24,709.06 – $24,024.04 = $685.02.
- Multiply the service portion by the DWC payment adjustment of 235% =

$1,609.80.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $24,024.04 + $1,609.80 = $25,633.84.

3. The DWC finds the MAR for CPT 63685 is $25,633.84. The respondent paid $25,633.28. No additional payment 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 20, 2023
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.