



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS SURGICAL CENTER

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-17-3323-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2017 Texas Workers' Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: \$324.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual believes no additional payment is due for code 25609."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 10, 2017	Ambulatory Surgery, Procedure Code 25609	\$324.85	\$94.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402 sets out the medical fee guideline for ambulatory surgery centers.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
 - 725 – APPROVED NON-NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153(C)
 - 763 – PAID PER ASC FG AT 235%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (W/SIGNED CERT) NOT REQUESTED: RULE 134.402(G)

Issues

- What is the recommended reimbursement for the disputed health care?
- Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards ambulatory surgical facility services with payment subject to 28 Texas Administrative Code §134.402(f), which requires the maximum allowable reimbursement (MAR) shall be the Medicare ASC amount applying Medicare Ambulatory Surgical Center payment policies and Outpatient Prospective Payment System (OPPS) formula and factors—including ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES—effective for the date of service, as published in the Federal Register, available at <http://www.cms.gov>.

The following minimal modifications apply as specified in Rule §134.402(f):

- (2) Reimbursement for device intensive procedures shall be:
 - (A) the sum of:
 - (i) the ASC device portion; and
 - (ii) the ASC service portion multiplied by 235 percent; or

The only issue in dispute is the amount of the fee to be paid. Reimbursement is calculated as follows:

- ASC Surgical code 25609, service date February 10, 2017, has status indicator J8 denoting a device-intensive procedure paid per Rule §134.402(f)(2). The Addendum AA rate for this procedure is \$3,679.62. This amount is divided in two halves representing the labor-related and non-labor-related portions of \$1,839.81 each. The labor-related half is multiplied by the facility wage index of 0.9123 for a geographically adjusted labor portion of \$1,678.46. This is added back to the non-labor half. The sum is the Medicare ASC facility rate of \$3,518.27. The device-offset amount from Medicare's ASC Device Adjustment Policy Table is \$2,239.28. This amount is subtracted from the facility rate, leaving a service portion of \$1,278.99, multiplied by the division's ASC conversion factor of 235% is \$3,005.63. The device portion is added back to the service portion for a MAR of \$5,244.91.

2. The total allowable reimbursement for the services in dispute is \$5,244.91. The insurance carrier paid \$5,150.81. The amount due to the requestor is \$94.10.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$94.10.

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor 94.10, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	August 17, 2017 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.