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
BAYLOR SURGICARE OF PLANO

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-1807-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 8, 2021

REQUESTOR'S POSITION SUMMARY

"At this time we are requesting that this claim paid in accordance with the 2021 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $7,956.04

RESPONDENT'S POSITION SUMMARY

"PAYMENT WAS ALLOWED PER DEVICE INTENSIVE METHOD."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12, 2021	Ambulatory Surgical Care Services (ASC) CPT Code 63650 (x2)	$6,937.99 x 2 = $13,875.98	$0.00
	ASC Services for HCPCS Code C1897	$0.00	$0.00
TOTAL		$7,956.04	$0.00

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-131-Claim specific negotiated discount.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - D25-Approved non network provider for Workwell.
   - 723-Supplemental reimbursement allowed after a reconsideration of services.
   - 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).
   - 923-Overpayment has occurred. Request for refund will be sent separately.
   - 763-Payment allowed per Device Intensive Methodology.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on March 12, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $7,956.04 for ASC services rendered on March 12, 2021.
2. The respondent contends that reimbursement of $12,798.50 was made per the fee guideline.
3. The fee guidelines for disputed services is found in 28 TAC §134.402.

   28 TAC §134.402(b) (6) states,

   > Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   28 TAC §134.402(d) states,

   > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   The disputed services are described as:

   - 63650- "Percutaneous implantation of neurostimulator electrode array, epidural."
   - C1897- "Lead, neurostimulator test kit (implantable)."

4. To determine the appropriate reimbursement for CPT codes 63650 the DWC refers to 28 TAC §134.402(f).

   A. Per ADDENDUM AA, CPT codes 63650 is a device intensive procedure.

   28 TAC §134.402(f)(2)(A)(i)(ii) states,

   > 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 as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (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.

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 63650 CY 2021 = $6,160.68

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for 63650 CY 2021 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 code 63650 CY 2021 is $4,473.13.
  This number is divided by 2 = $2,236.57.
  This number multiplied by the City Wage Index for Plano, Texas of 0.9744 = $2,179.31.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement = $4,415.88.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,445.20.

  Multiply the service portion by the DWC payment adjustment of 235% = $3,396.22.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $6,366.90.

The DWC finds the MAR for CPT code 63650 is $6,366.90. The requestor billed for 2 units = $12,733.80.

5. The respondent paid $5,919.90 for HCPCS code C1897 based upon the fee guideline. The requestor did not seek separate reimbursement for the implantables; therefore, the payment was not per the fee guidelines.

6. The DWC finds the MAR for the ASC services rendered on March 12, 2021 is $12,733.80. The respondent paid $12,798.50. The DWC finds the requestor is not due additional reimbursement.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		07/08/2021
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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 TAC §141.1(d).

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