



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Breckenridge Surgery Center

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-24-1348-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

February 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 27, 2023	64831, 64832, 69990	\$3,112.39	\$0.00
Total		\$3,112.39	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. The requestor did submit a copy of their reconsideration that states, "CPT codes 64832, and 69990 were denied stating packaged service. The services were done on separate nerves and CPT 64832 was billed for the additional nerve. The physician was paid for all services... ..we should be paid also."

Amount in Dispute: \$3,112.39

Respondent's Position

"Payment was made for the primary procedure code 64831-F3. 64832-XS-F3 is an add on code that has a status indicator of N1 meaning it's a packaged service/item and no separate payment is made per the Addendum DD1 – ASC Payment Indicator for CY2024. Our position is that no additional payment is due."

Response submitted by: Texas Mutual Insurance

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:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3 – In accordance with TDI-DWC Rule 134,804, this bill has been identified as a request for reconsideration or appeal.
- CAC-18 – Exact duplicate claim/service.
- CAC – 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.
- DC7 – Duplicate appeal. Network contract applied by Workwell, TX network.
- D25 – Approved non network provider for Workwell, TX network claimant per Rule 1305.153(C).
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 662 – Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. What rule applies for determining reimbursement for the disputed services?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for surgery rendered February 2023 in an ambulatory surgical center. The insurance carrier reduced the service based on workers' compensation fee schedule and packaging.

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.

Procedure Code 64831 – F3 has a payment indicator of A2. DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent. The following formula was used to calculate the MAR:

- The Medicare ASC reimbursement for code 64831 for applicable date of service is \$854.03.
- The Medicare ASC reimbursement is divided by 2 = \$427.02.
- This number multiplied by the CBSA Richardson, Texas of 0.9688 = \$413.70.
- Add these two together = \$840.72.
- To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = \$1,975.70.

Procedure Code 69990 has a payment indicator of N1 – Packaged service/item; no separate payment.

Procedure Code 64832 – XS – F3 has a payment indicator of N1 – Packaged service/item; no separate payment.

2. The DWC finds the MAR is 1,975.70. The respondent paid \$1,975.43. 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 additional reimbursement for the disputed services.

Authorized Signature

_____	_____	March 6, 2024
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 electrónico CompConnection@tdi.texas.gov.