Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

KSF ORTHOPAEDIC SURGERY CENTER
17060 RED OAK DRIVE
HOUSTON, TX 77090

MFDR Tracking #: M4-09-A801-01

Respondent Name and Box #:

AMERICAN HOME ASSURANCE CO.
Rep Box # 19

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Gallagher Bassett submitted a $4672.60 payment EOB to the facility. This was not according to the Texas Workers' Compensation Fee Schedule, so a reconsideration letter was mailed on 02/23/09 and faxed 03/25/09 and on additional payment was made of $0.00. A second letter was sent on 04/30/09 with no additional payment made. To date we are still underpaid by the carrier in the amount of $4194.17."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $4,194.17
3. CMS 1500
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The carrier maintains that the payment amounts made to date are correct for the date of service made the basis of this medical fee dispute."

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10/1/08	29828	W1	1-4	$3,236.04
	29826-RT-SG	59	1-3, 5	$372.01
	29827-RT-SG	W1	1-3, 6	$0.00
	C1713	No code	7	$0.00
Total /Due:				$3,608.05

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective 08/31/08, set out the reimbursement guidelines.

1. The disputed services were denied or reduced reimbursement based upon:
   - W1-Workers Compensation Fee Schedule Adjustment; and
   - 59-Processed based on multiple or concurrent procedure rules."
2. The 10/1/08 operative report indicates the claimant underwent the following:
   - "Exam under anesthesia, arthroscopy right shoulder with subacromial decompression, 29826;
   - Arthroscopic repair of rotator cuff, 29827;
   - Arthroscopic biceps tenodesis, 29828."
3. Per Medicare Surgery Ground Rules, "***Same Endoscopic Family*** When two or more endoscopies are billed that are both in the same endoscopic family, Medicare prices the highest allowed procedure at 100 percent of the fee amount. The other procedures are priced by subtracting the fee amount of the basic endoscopy from their fee amounts." The Requestor billed CPT codes 29826, 29827 and 29828 that are in the same endoscopic family of CPT code 29805. The 2008 fully implemented payment for 29805 is $1,191.53. All three billed codes, CPT codes 29826, 29827 and 29828 have the same fee amount per the Addendum AA ASC Surgical Procedure for CY 2008 of $1,892.32; therefore, the adjustment in reimbursement is applicable to either code. The Division will apply the adjustment to CPT code 29826 and 29827.
4. Per Rule 134.402(f) reimbursement for non-device intensive procedure, CPT code 29828 is:

   The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2008 = $1,892.32. The national reimbursement is divided by 2 = $946.16.

   This number X City Conversion Factor/CMS Wage Index for Houston $946.16 X 0.9939 = $940.39.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $940.39 + $946.16 = $1,886.55.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,886.55 X 235% = $4,433.39.

   Therefore, the MAR for CPT code 29828 is $4,433.39. The insurance carrier paid $1,197.35. The difference between the MAR and paid is $3,236.04, this amount is recommended for additional reimbursement.
5. Per Rule 134.402(f) reimbursement for non-device intensive procedure, CPT code 29826-RT-SG is:

   The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2008 = $1,892.32 minus $1,191.53 the same endoscopic family base value of 29805 is $700.79.
   The national reimbursement is divided by 2 = $350.40.

   This number X City Conversion Factor/CMS Wage Index for Houston $350.40 X 0.9939 = $348.26.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $348.26 + $350.40 = $698.66.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $698.66 X 235% = $1,641.85.

   This amount times 50% for the multiple procedure rule is $820.93.

   Therefore, the MAR for CPT code 29826-RT-SG is $820.93. The insurance carrier paid $448.92. The difference between the MAR and paid is $372.01, this amount is recommended for additional reimbursement.
6. Per Rule 134.402(f) reimbursement for non-device intensive procedure, CPT code 29827-RT-SG is:

   The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2008 = $1,892.32 minus $1,191.53 the same endoscopic family base value of 29805 is $700.79.
   The national reimbursement is divided by 2 = $350.40.

   This number X City Conversion Factor/CMS Wage Index for Houston $350.40 X 0.9939 = $348.26.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the

national reimbursement $348.26 + $350.40 = $698.66.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $698.66 X 235% = $1,641.85.

This amount times 50% for the multiple procedure rule is $820.93.

Therefore, the MAR for CPT code 29826-RT-SG is $820.93. The insurance carrier paid $1,466.33. Per Rule 133.260 (f) "The health care provider shall submit a refund to the insurance carrier when the health care provider identifies an overpayment even though the insurance carrier has not submitted a refund request." In addition, Rule 133.260(a) "An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided." Based upon the submitted documentation a refund request has not been submitted by the insurance carrier. Therefore, the Requestor is due $0.00 additional reimbursement.

7. The Requestor noted on the DWC-60 table that for code C1713 an overpayment of $1,560.00 was made. Per Rule 133.260(f), the health care provider shall submit a refund to the insurance carrier when the health care provider identifies and overpayment…" Therefore, the Requestor is due $0.00 additional reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1, 133.260
28 Texas Administrative Code §134.402 effective 08/31/08

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$3,608.05** plus applicable accrued interest per Division Rule §134.130, due within 30 days of receipt of this Order.

ORDER:

		9/3/09
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

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