



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ROC ASC

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-10-3306-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MARCH 10, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "1305.153 Provider Reimbursement. (a) The amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider or group of providers. However we are in receipt of a denial of payment for the above referenced claim."

Amount in Dispute: \$1,171.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier noted in its first EOB regarding date of service 6/20/09 that the contracted amount due was \$1,053.17. Thereafter, there was an adjustment noting that the negotiated total should be \$880.00. The carrier has already made payment in the amount of \$1171.15 and owes nothing further. This matter should be dismissed."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2009	ASC Services for CPT Code 29827-LT	\$434.72	\$434.72
	ASC Services for CPT Code 29826-LT	\$0.00	\$0.00
	HCPCS Code L8699 (X4)	\$736.43	\$736.43
TOTAL		\$1,171.15	\$1,171.15

FINDINGS AND DECISION

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

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract and that the

insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.

4. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated January 26, 2009
 - 45-Charges exceed your contracted/legislated fee arrangement.
 - 793-Reduction due to PPO contract.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Did the requestor support position that additional reimbursement is due for ASC services for code 29827-LT?
3. Did the requestor support position that additional reimbursement is due for HCPCS code L8699?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement.

Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract under which fee are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.

28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:

(1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

(2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

On November 9, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. 28 Texas Administrative Code §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."

28 Texas Administrative Code §134.402(f)(1)(B)(i) and (ii), which 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: (1) Reimbursement for non-device intensive procedures shall be: ((B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:

(i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission; and

(ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

CPT code 29827 is defined as "Arthroscopy, shoulder, surgical; with rotator cuff repair."

28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for CPTcode 29827 is:

The Medicare fully implemented ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures fully implemented ASC relative payment weight for CY 2009 = 46.3214.

This number is multiplied by the 2009 Medicare ASC conversion factor of 46.3214 X \$41.393 = \$1,917.38.

The Medicare fully implemented ASC reimbursement rate is divided by 2 = \$958.69.

This number X City Conversion Factor/CMS Wage Index for Houston is \$958.69 X 0.9838 = \$943.15.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement \$958.69 + \$943.15 = \$1,901.84.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment \$1,901.84 X 153% = \$2,909.81.

CPT code 29827 is subject to multiple procedure discounting; therefore, \$2,909.81 X 50% = \$1,454.90.

The MAR for CPT code 29827 is \$1,454.90. The insurance carrier paid \$434.73. The difference between amount due and paid equals \$1,020.17. The requestor is seeking a lesser amount of \$434.72 , this amount is recommended for reimbursement.

3. HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified." To determine the MAR the Division refers to 28 Texas Administrative Code §134.402(f)(1)(B)(i). The requestor submitted a copy of the implant invoice that indicates that the cost is \$200.00 each. The requestor is billing for four units; therefore, \$200.00 X 4 = \$800. Per 28 Texas Administrative Code §134.402(f)(1)(B)(i), this amount plus 10% add on = \$880.00. The respondent paid \$143.57. the difference between amount paid and due is \$736.43; this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is \$1,171.15.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,171.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

04/10/2014
Date

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 **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. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

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