



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

North Garland Surgery Center

**Respondent Name**

Travelers Property Casualty Co

**MFDR Tracking Number**

M4-14-1309-01

**Carrier's Austin Representative Box**

Box Number 05

**MFDR Date Received**

January 9, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "At this time we are requesting that this claim paid in accordance with the 2013 Texas Workers Compensation Fee Schedule and Guidelines."

**Amount in Dispute:** \$310.12

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "As the admission has been overpaid, the Carrier contends the Provider is not entitled to additional reimbursement."

**Respondent:** Travelers

**SUMMARY OF FINDINGS**

<b>Dates of Service</b>	<b>Disputed Services</b>	<b>Amount In Dispute</b>	<b>Amount Due</b>
September 5, 2013	29827, 29820, 29826, L8699	\$310.12	\$0.00

**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 medical fee disputes.
- 28 Texas Administrative Code §134.402 sets out reimbursement guidelines for medical services, charges and payments.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97 – Charge for this procedure exceeds Medicare ASC Schedule Allowance
  - 851 – Charge exceeds mult proc rules

**Issues**

- What is the applicable rule to calculate reimbursement?
- Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Administrative Code §134.402(f) 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:

(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or

(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. ...

Review of the submitted documentation finds a request for implantables was made and considered by the carrier. The services in dispute will be calculated at the Medicare ASC Facility reimbursement amount multiplied by 153% or

Submitted Procedure Code	National Reimbursement from Addendum AA	Statistical Area Number	Wage Index for ASC	Divide National Reimbursement by 2	Multiply by National Wage Index	Add to National Reimbursement Total	Medicare Adjusted ASC Reimbursement	Total MAR
29827	\$2177.30	19124	0.9844	$2177.30 \div 2 = 1,088.65$	$1088.65 \times 0.9844 = 1,071.67$	$1071.67 + 1088.65 = 2160.32$	\$2,160.32	$2160.32 \times 153\% = \$3,305.29$
29820	$\$2177.30 \times 50\%$ (multiple procedure discount) = 1,088.65	19124	0.9844	$1,088.65 \div 2 = 544.32$	$1088.65 \times 0.9844 = 535.83$	$535.83 + 544.32 = 1,080.15$	\$1,060.15	$1080.15 \times 153\% = \$1,652.83$
29826	$\$1184.89 \times 50\%$ (multiple procedure discount) = 592.45	19124	0.9844	$592.45 \div 2 = 296.23$	$296.23 \times 0.9844 = 291.61$	$291.61 + 296.23 = 587.84$	\$587.84	$587.84 \times 153\% = \$899.40$
							Total	\$5,857.32

Submitted Code	Amount billed	Units	Implantable Description	Invoice Amount	Did documentation support item met the definition of "implantable"	Implants Maximum allowable reimbursement
L8699	335.20	1	Express w w/3 needles	\$170.20	No	n/a Rule 134.402(b)(5) not met as item does not meet the definition of "implantable". Documentation does not support item was implanted, embedded, inserted, or otherwise applied
		1	VARP P90	\$165.00	no	n/a Rule 134.402(b)(5) not met as item does not meet the definition of "implantable". Documentation does not support item was implanted, embedded, inserted, or otherwise applied
L8699	2766.00	3	Healix Advance Knotless Peek Anchor 4.75mm	\$1,437.00	Yes (2 units only supported by documentation)	Cost $\$479.00 \times 2 = 958.00 \times 10\% = 1,053.60$
		2	L/P Anchor Healix 4.5	\$824.00	Yes	Cost $\$412.00 \times 2 = 814.00 \times 10\% = \$895.40$
		1	Healix Advance Knotless Peek Anchor 5.5mm	\$505.00	No	n/a Rule 134.402(b)(5) not met as item does not meet the definition of "implantable". Documentation does not support item was implanted, embedded, inserted, or otherwise applied

			Total	\$3,101.20		\$1,949.20

2. The total allowable for the disputed services is \$7,806.52. The carrier paid \$8,992.44. No additional payment can be recommended.

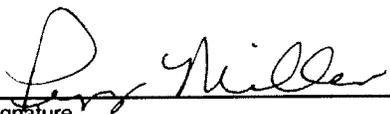
**Conclusion**

For the reasons stated above, the Division 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 Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

  
 Signature \_\_\_\_\_

Peggy Miller  
 Medical Fee Dispute Resolution Officer

January 8, 2015  
 Date

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request 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 §141.1(d).

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