



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

CASTLE HILLS ASC LP

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-15-1844-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

FEBRUARY 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient was seen in the office, authorization request was submitted to utilization review, the surgery was approved and therefore scheduled and performed. Payment was received on 04/10/2014. Along with an Explanation of Benefits indicating the amount that it was paid. However, the rates used were incorrect as they should have been calculated for the facility claim in accordance with 235% of Medicare's rate, since implant was used and paid for by the facility."

Amount in Dispute: \$2,735.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 20, 2014, Ambulatory Surgical Care for CPT Code 26541-SG, \$2,735.82, \$1,264.02

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.

Background

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

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
 - W1-Workers compensation state fee schedule adjustment.
 - 193-Original payment decision is being maintained. This claim was processed properly the first time.
 - 1014-The attached billing has been re-evaluated at the request of the provider. Based on the re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
 - 5261-Letter-Please see additional message codes for information related to this review.

Issues

Is the requestor entitled to additional reimbursement for code 26541-SG?

Findings

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.”

CPT code 26541 is defined as “Reconstruction, collateral ligament, metacarpophalangeal joint, single; with tendon or fascial graft (includes obtaining graft).”

28 Texas Administrative Code §134.402(f)(1)(A) 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.”

According to Addendum AA, CPT code 26541 is a non-device intensive procedure.

The City Wage Index for San Antonio, TX is 0.8911.

The Medicare fully implemented ASC reimbursement for code 26541 CY 2014 is \$1,231.21.

To determine the geographically adjusted Medicare ASC reimbursement for code 26541:

The Medicare fully implemented ASC reimbursement rate of \$1,231.21 is divided by 2 = \$615.60

This number multiplied by the City Wage Index is $\$615.60 \times 0.8911 = \548.56 .

Add these two together $\$548.56 + \$615.60 = \$1,164.16$.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

$\$1,164.16 \times 235\% = \$2,735.77$. The respondent paid \$1,471.75. The difference between the MAR and amount paid is \$1,264.02.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,264.02.

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 \$1,264.02 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

06/10/2015
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, 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 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 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.