



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

STONEGATE SURGERY CENTER

Respondent Name

AMERICAN STATES INSURANCE CO

MFDR Tracking Number

M4-15-2965-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

MAY 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim paid CPT 29888 and 29882 incorrectly according to the Medicare 2014 fee schedule. The reimbursement rate for this claim is 153% of Medicare fee schedule. The correct allowed amount for code 29888 is \$5383.11 and with the multiple procedure reduction for 29882 is 891.68 for a total reimbursement of \$6274.79. Review of this claim shows that we should be reimbursed an additional payment of \$3640.42 on this claim."

Amount in Dispute: \$3,640.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2014	Ambulatory Surgical Care for CPT Code 29888-RT	\$3,437.49	\$3,437.48
	Ambulatory Surgical Care for CPT Code 29882-RT	\$202.93	\$202.92
TOTAL		\$3,640.42	\$3,640.40

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:
 - MT12-Diagnosis Code indicates severe injury.
 - U849-This multiple procedure was reduced 50%% according to the fee schedule or % obtain UCR Vendor Name %.
 - No reduction available.
 - Procedure charge exceeds FS allowance.
 - P12-Workers compensation jurisdictional fee schedule adjustment.
 - W3-Request for reconsideration.
 - 59-Processed based on multiple or concurrent procedure rules.
 - P300-The amount paid reflects a fee schedule reduction.
 - MT13-This claim has exceeded \$5,000.00.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 19, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Is the requestor entitled to additional reimbursement for code 29888-RT?
2. Is the requestor entitled to additional reimbursement for code 29882-RT?

Findings

1. 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."

On the disputed date of service, the requestor billed CPT codes 29888-RT and 29882-RT.

CPT code 29888 is defined as "Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction."

The requestor appended the "RT- Right side (used to identify procedures performed on the right side of the body)" modifier to code 29888.

The issue in dispute is whether the requestor is due additional reimbursement for code 29888-RT .

A review of the submitted medical bill indicates that the requestor sought separate reimbursement for the implants; therefore, 28 Texas Administrative Code §134.402(f)(1)(B) applies to determine maximum allowable reimbursement (MAR).

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

According to Addendum AA, CPT codes 29888 is a non-device intensive procedure.

The City Wage Index for Austin, TX is 0.9576.

The Medicare fully implemented ASC reimbursement for code 29888 CY 2014 is \$3,594.58.

To determine the geographically adjusted Medicare ASC reimbursement for code 29888:

The Medicare fully implemented ASC reimbursement rate of \$3,594.58 is divided by 2 = \$1,797.29.

This number multiplied by the City Wage Index is $\$1,797.29 \times 0.9576 = \$1,721.08$.

Add these two together $\$1,797.29 + \$1,721.08 = \$3,518.37$.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153%.

$\$3,518.37 \times 153\% = \$5,383.10$. The respondent paid \$1,945.62. As a result, additional reimbursement of \$3,437.48 is recommended.

2. CPT code 29882 is defined as “Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral).”

The requestor appended the “RT- Right side (used to identify procedures performed on the right side of the body)” modifier to code 29882.

According to Addendum AA, CPT codes 29882 is a non-device intensive procedure and is subject to multiple procedure discounting.

The Medicare fully implemented ASC reimbursement for code 29882 CY 2014 is \$1,190.84.

Using the above formula the Division finds the MAR is \$891.67. The respondent paid \$688.75. As a result, the requestor is due an additional reimbursement of \$202.92.

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 \$3,640.40.

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 \$3,640.40 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

07/09/2015
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.