



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

DENTON SURGICARE PARTNERS

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-15-3423-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

JUNE 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The EOB we received states that the unpaid charge of CPT 29848 was denied for provider not being within the Liberty Mutual Health Care Network. Attached is the authorization letter from Liberty Mutual Health Network that clearly states in the verbiage that our request to continue as an out of network is medically necessary and authorized."

Amount in Dispute: \$2,729.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge for services of March 26, 2015 is currently being reprocessed for payment. It was determined that the nurse case manager gave authorization for the out of network facility but the information was not correctly added to the claim file."

Respondent's Supplemental Position Summary: "Attached is the payment EOB for reimbursement issued in response to M4-15-3423-01."

Copy of check number 0029034776 issued on July 15, 2015 for \$2,729.44 was attached to Supplemental Response.

Responses Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 26, 2015, Ambulatory Surgical Care for CPT Code 29848, \$2,729.43, \$0.00

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:
  - Z710-The charge for this procedure exceeds the fee schedule allowance.
  - P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
  - W3-Additional payment made on appeal/reconsideration.

## Issues

Is the requestor entitled to reimbursement for code 29848?

## 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.”

On the disputed date of service, the requestor billed CPT code 29848.

CPT code 29848 is defined as “Endoscopy, wrist, surgical, with release of transverse carpal ligament

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 codes 29848 is a non-device intensive procedure.

The City Wage Index for Denton, TX is 0.9703.

The Medicare fully implemented ASC reimbursement for code 29848 CY 2015 is \$1,179.31

**To determine the geographically adjusted Medicare ASC reimbursement for code 29848:**

The Medicare fully implemented ASC reimbursement rate of \$1,179.31 is divided by 2 = \$589.65.

This number multiplied by the City Wage Index is  $\$589.65 \times 0.9703 = \$572.13$ .

Add these two together  $\$572.13 + \$589.65 = \$1,161.78$ .

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

$\$1,161.78 \times 235\% = \$2,730.18$ . The respondent paid \$2,729.44. The requestor is seeking \$2,729.43. As a result, additional reimbursement is not 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

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

07/29/2015  
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.**