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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DEEPAK V. CHAVDA, MD, PA

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-16-0639-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
NOVEMBER 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary was not submitted in dispute packet.

Amount in Dispute: $4,980.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denied 29888 as Documentation does not support level of service billed. (X901). Provider did not do formal repair but a thermal tightening with ArthroCare wand. Per AAOS April 2005 Bulletin 'Accurately code knee procedures' Some orthopaedic surgeons have begun using thermal treatments to tighten a stretched ACL or to treat ACL laxity. CPT warns that it is incorrect to select a code that merely approximates the service being rendered and specifies that the anatomically specific unlisted code should be used. This means that code 29888 should not be used for thermal ACL procedures."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 22, 2014	CPT Code 29888-RT Knee Arthroscopy	$4,980.00	$1,933.75

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - X901-Documentation does not support level of service billed.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- W3-Additional payment made on appeal/reconsideration.

Issues

Does the documentation support billing CPT code 29888-RT? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for code 29888-RT based upon the service was not documented. The respondent contends that payment is not due because "Provider did not do formal repair but a thermal tightening with ArthroCare wand. Per AAOS April 2005 Bulletin 'Accurately code knee procedures' Some orthopaedic surgeons have begun using thermal treatments to tighten a stretched ACL or to treat ACL laxity. CPT warns that it is incorrect to select a code that merely approximates the service being rendered and specifies that the anatomically specific unlisted code should be used. This means that code 29888 should not be used for thermal ACL procedures."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

On the disputed date of service the requestor billed CPT codes 29888-RT, 29881-59-RT, 29876-59-RT and 29877-59-RT. The requestor is only disputing the denial of payment for code 29888-RT.

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

The requestor appended modifiers "RT-right side."

The Operative Report indicates "The anterior notch was next entered. He had significant amount of scar and fibrous tissue over the healing from the ACL tear on the femoral groove, which was then reattached to the PCL gaining stability. All the edges and fraying was debrided, and repair of the ACL bundles partial tear was carried out using electrothermal modifications using ArthroCare wand. Notchplasty was also carried out."

The Division finds that ACL repair was performed; therefore, reimbursement is recommended per the Division's fee guideline.

The Division reviewed the explanation of benefits, and finds that the respondent paid 100% of the MAR for code 29876-59-RT and 50% for code 29881-59-RT. Per Medicare fee schedule, code 29888 has the higher value; therefore, should be reimbursed at 100%.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2014 DWC conversion factor for this service is 69.98.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76110, which is located in Fort Worth, Texas; therefore, the Medicare participating amount is based on locality "Fort Worth, Texas".

The Medicare participating amount for code 29888 is $989.89.

Using the above formula, the Division finds the MAR is $1,933.75. The respondent paid $0.00. As a result, reimbursement of $1,933.75 is recommended.

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 $1,933.75.

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 $1,933.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/19/2015
Signature	Medical Fee Dispute Resolution Officer	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.