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
GRAPEVINE SURGERY CENTER

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-16-3224-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the allowed amount of the procedure on the attached claim. Please recalculate the fee schedule allowed amount being sure to use the correct National Rate and Wage index for the city where the facility is located."

Amount in Dispute: $809.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs…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

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2016	Ambulatory Surgical Care CPT Code 27301-RT	$809.79	$839.58

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:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to additional reimbursement for code 27301-RT?

Findings

According to the explanation of benefits, the respondent paid $1,004.67 for code 29828-RT based upon the fee schedule.

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."

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 27301-RT is a non-device intensive procedure.

The Medicare fully implemented ASC reimbursement for code 27301 CY 2016 is $790.85.

The 2016 City Wage Index for Grapevine, Texas is 0.9847.

To determine the geographically adjusted Medicare ASC reimbursement for code 27301-RT:

The Medicare fully implemented ASC reimbursement rate of $790.85 is divided by 2 = $395.42.

This number multiplied by the City Wage Index is $395.42 X 0.9847 = $389.37.

Add these two together $395.42 + $389.37 = $784.79.

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

28 Texas Administrative Code §134.402(e)(2) states, "Regardless of billed amount, reimbursement shall be: if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables." A review of the submitted documentation finds that the disputed services are not subject to a contracted fee schedule; therefore, reimbursement is per the MAR.

$784.79 X 235% = $1,844.25. The respondent paid $ 1,004.67. The difference between the MAR and amount paid is $839.58; this amount is recommended for additional payment per 28 Texas Administrative Code §134.402(e)(2).

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 $839.58.

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 $839.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/18/2016
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, 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.