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
NORTH GARLAND SURGERY CENTER

Respondent Name
TRUMBULL INSURANCE CO

MFDR Tracking Number
M4-19-3246-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
FEBRUARY 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2018 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $1,827.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines, Rule 134.402."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2018	Ambulatory Surgical Care Services CPT Code 24545-LT	$1,827.83	$74.20

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, effective May 31, 2012 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.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - 1115-We find the original review to be accurate and are unable to recommend any additional allowance.
   - 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.

- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on November 15, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,827.83 for ASC services related to CPT code 24545-LT rendered to the injured worker on November 15, 2018. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.
2. Per the submitted explanation of benefits, the insurance carrier paid for CPT code 24545-LT based upon the fee guideline.
3. To determine the appropriate reimbursement for CPT code 24545-LT the division refers to 28 Texas Administrative Code §134.402(f).

   A. Per ADDENDUM AA, CPT code 24545 is a device intensive procedure.

   28 Texas Administrative Code §134.402(f)(2)(A)(i)(ii) 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: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

   The following formula was used to calculate the MAR:

   - Step 1 calculating the device portion of the procedure:

     The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 24545-LT for CY 2018 = $10,122.92.

     This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 42.68% = $4,320.16.

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare ASC reimbursement rate for code 24545 is $7,083.96.
     The Medicare ASC reimbursement rate of $7,083.96 is divided by 2 = $3,541.98.
     This number multiplied by the City Wage Index for Garland, TX $3,541.98 X 0.9848 = $3,488.14.
     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$7,030.12.
     The service portion is found by taking the geographically adjusted rate of $7,030.12 minus the device portion of $4,320.16 = $2,709.96.

     Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $2,709.96 X 235% = $6,368.40.

     The MAR is determined by adding the sum of the reimbursement for the device portion of $4,320.16 + the service portion of $6,368.40 = $10,688.56. The insurance carrier paid $10,614.36. As a result, the difference between the MAR and amount paid of $74.20 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $74.20.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $74.20, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		03/28/2019
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 Rule §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 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. **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.