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
PHYSICIANS SURGICAL CENTER

Respondent Name
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-19-3713-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
APRIL 5, 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 Center."

Amount in Dispute: $547.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date of service in dispute was processed in accordance with Texas Workers' Compensation Guidelines and 28 TAC 134.402."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 30420	$64.95	$0.00
	Ambulatory Surgical Care Services CPT Code 21235	$32.48	$0.00
	Ambulatory Surgical Care Services CPT Code 20912	$21.38	$0.00
	Ambulatory Surgical Care Services CPT Code 30140	$14.42	$0.00
	Ambulatory Surgical Care Services CPT Code 30140	$512.36	$512.36
TOTAL		$547.97	$512.36

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.
   - 300-An allowance has been made for a bilateral procedure.
   - 851-The allowance was adjusted in accordance with multiple procedure rules and/or guidelines.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - W3-Additional payment made on appeal/reconsideration.
   - 1115-We find the original review to be accurate and are unable to recommend any additional allowance.
   - 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 August 21, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $547.97 for ambulatory surgical care services rendered to the injured worker on August 21, 2018. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.
2. 28 Texas Administrative Code §134.402(b) (6) states,

   > Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means 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.

   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, including the following paragraphs.

   The disputed services are defined as:

   - CPT code 30420 is defined as "Rhinoplasty, primary; including major septal repair."
   - CPT code 21235 is defined as "Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)."
   - CPT code 20912 is defined as "Cartilage graft; nasal septum."
   - CPT code 30140 is defined as "Submucous resection inferior turbinate, partial or complete, any method."
3. Per ADDENDUM AA, CPT code 30420 is a non-device intensive procedure.

   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: A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

The following formula was used to calculate the MAR:

The Medicare fully implemented ASC reimbursement for code 30420 CY 2018 is $2,142.48.

The Medicare fully implemented ASC reimbursement rate of $2,142.48 is divided by 2 = $1,071.24.

This number multiplied by the City Wage Index for Fort Worth, Texas is $1,071.24 X 0.9590 = $1,027.31.

Add these two together = $2,098.55.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $4,931.59. The respondent paid $4,931.62; therefore, additional reimbursement is not recommended.

4. Per ADDENDUM AA, CPT code 21235 is a non-device intensive procedure.

   The following formula was used to calculate the MAR:

   The Medicare fully implemented ASC reimbursement for code 21235 CY 2018 is $2,142.48.

   The Medicare fully implemented ASC reimbursement rate of $2,142.48 is divided by 2 = $1,071.24.

   This number multiplied by the City Wage Index for Fort Worth, Texas is $1,071.24 X 0.9590 = $1,027.31.

   Add these two together = $2,098.55.

   To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $4,931.59. This code is subject to multiple procedure rule discounting of 50% = $2,465.79. The respondent paid $2,465.81; therefore, additional reimbursement is not recommended.

5. Per ADDENDUM AA, CPT code 20912 is a non-device intensive procedure.

   The following formula was used to calculate the MAR:

   The Medicare fully implemented ASC reimbursement for code 20912 CY 2018 is $1,411.94.

   The Medicare fully implemented ASC reimbursement rate of $1,411.94 is divided by 2 = $705.97.

   This number multiplied by the City Wage Index for Fort Worth, Texas is $705.97 X 0.9590 = $677.02.

   Add these two together = $1,382.99.

   To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $3,250.02. This code is subject to multiple procedure rule discounting of 50% = $1,625.01. The respondent paid $1,625.03; therefore, additional reimbursement is not recommended.

6. Per ADDENDUM AA, CPT code 30140-LT is a non-device intensive procedure.

   The following formula was used to calculate the MAR:

   The Medicare fully implemented ASC reimbursement for code 30140 CY 2018 is $952.18.

   The Medicare fully implemented ASC reimbursement rate of $952.18 is divided by 2 = $476.09.

This number multiplied by the City Wage Index for Fort Worth, Texas is $476.09 X 0.9590 = $456.57.

Add these two together = $932.66.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,191.75. This code is subject to multiple procedure rule discounting of 50% = $1,095.87. The respondent paid $1,095.88; therefore, additional reimbursement is not recommended.

7. The requestor billed code 30140-RT.

   Per Medicare's Claim Processing Manual, Chapter 14-Ambulatory Surgical Centers, 40.5 - Payment for Multiple Procedures, "A procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with "2" in the units field on one line. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting. For example, if lavage by cannulation; maxillary sinus (antrum puncture by natural ostium) (CPT code 31020) is performed bilaterally in one operative session, report 31020 on two separate lines or with "2" in the units field. Depending on whether the claim includes other services to which the multiple procedure discount applies, the contractor applies the multiple procedure reduction of 50 percent to the payment for at least one of the CPT code 31020 payment rates."

   Therefore, as noted above the MAR is $2,191.75. This code is subject to multiple procedure rule discounting of 50% = $1,095.87. The respondent paid $547.94; therefore, additional reimbursement of $547.93 or less. The requestor is seeking a lesser amount of $512.36; this amount 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 $512.36.

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 $512.36, 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	05/09/2019 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.