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
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-19-3939-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
APRIL 26, 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"

Amount in Dispute: $1,129.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have re-reviewed and stand on the prior reconsideration bill #79482 and 83427. No additional allowance, because prior images did not request separate reimbursement for Implants but to be paid at the higher percentage for not requesting separate for implantables. The MFDR received is now indicating they want separate reimbursement for Implants and that would be a corrected billing and per 95-day Rule (initial bills only) the DWC Rule 133.20(b) we are standing on the prior review and not allowing additional ."

Response Submitted By: AViDEL

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2018	Ambulatory Surgical Care Services (ASC) Code 27415-LT	$1,129.05	$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, 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. 28 Texas Administrative Code §133.10, effective April 1, 2014, sets out the required health care provider billing procedures.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medic al fee guideline.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - 375-Line 1 w/procedure code 27415 is repriced from $11,785.22 to $10,656.17 per Fee schedule rate, reimbursement are made as unit value times conversion factor times number of unites, where unit value = 10,656.17 conversion factor = 01, number of unites = 01. Line 1 w/procedure code 27415 is repriced from $10,656.17 to 10,656.17 as per state fee schedule or Medicare guidelines. Reimbursements are made at Per Unit Value times Cascading percentage, where Per Unit Value = $10,656.17 and Cascading percentage = 100%.
   - 95-Plan procedure not followed.
   - U03-The billed service was reviewed by UR and authorized.
   - 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 due additional reimbursement for ASC services related to CPT code 27415-LT rendered on September 13, 2018?

Findings

1. On the disputed date of service, the requestor billed $42,472.22 for CPT codes 27415-LT, 29888-LT, 29880-LT, C1713, C1762 and L8699. The respondent paid $15,321.95 for the disputed services. Per the Table of Disputed Services, the requestor is only seeking medical fee dispute resolution for code 27415-LT.
2. The respondent paid $10,656.17 for code 27415-LT based upon the fee guideline. The requestor is seeking additional reimbursement of $1,129.05.
3. 28 Texas Administrative Code §133.10(f)(1)(W) states,

   > All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1)The following data content or data elements are required for a complete professional or non-institutional medical bill related to Texas workers' compensation health care: (W) supplemental information (shaded portion of CMS-1500/field 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line.

   A review of the submitted medical bill finds the requestor did not indicate on fields 24d-24h a request for separate reimbursement for the implantables. Therefore, the requestor is not due separate reimbursement for the implantables.
4. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
   - 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.

CPT code 27415 is described as "Osteochondral allograft, knee, open."

5. To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.402(f)(1)(B).

   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.

   According to Addendum AA, CPT code 27415 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 27145 for CY 2018 = $10,122.22.

     This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 62.0% = $6,275.78.

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 27415 is $8,202.36.

     Per the Medicare fully implemented ASC reimbursement rate of $8,202.36 is divided by 2 = $4,101.18.

     This number multiplied by the City Wage Index for Garland, TX $4,101.18 X 0.9848 = $4,038.84.

     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$8,140.02.

     The service portion is found by taking the geographically adjusted rate of $8,140.02 minus the device portion of $6,275.78 = $1,864.24.

     Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,864.24 X 235% = $4,380.96.

The MAR is determined by adding the sum of the reimbursement for the device portion of $6,275.78 + the service portion of $4,380.96 = $10,656.74. The insurance carrier paid $10,656.17. 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

		05/16/2019
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 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.