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
TEXAS SURGICAL CENTER

Respondent Name
BERKLEY NATIONAL INSURANCE CO

MFDR Tracking Number
M4-19-4654-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2019 Texas Workers Compensation Fee Schedule and Guidelines FOR Ambulatory Surgical Centers."

Amount in Dispute: $988.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has been reimbursed based upon the Medical Fee Guidelines. The provider is not entitled to any additional reimbursement."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 29888	$988.51	$0.00
	ASC Services CPT Code 27405	$0.00	$0.00
	ASC Services CPT Code 29880	$0.00	$0.00
TOTAL		$988.51	$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.
   - P14-The benefit for this service is included in the pymt/allowance for another service/procedure that has been performed on the same day.
   - W3-Reporting purposes only.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor due additional reimbursement for ASC services related to CPT code 29888-RT rendered on January 10, 2019?

Findings

1. On the disputed date of service, the requestor billed $33,168.23 for CPT codes 29888-RT, 27405-RT, 29880-RT, C1713, and C1762. The respondent paid $9,994.37 for the disputed services. Per the Table of Disputed Services, the requestor is only seeking medical fee dispute resolution for code 29888-RT.
2. The respondent paid $5,554.31 for code 29888-RT based upon the fee guideline. The requestor is seeking additional reimbursement of $988.51.
3. 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 29888 is described as "Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction."

   Per CCI edits, the benefits for CPT code 29888 are not included in the benefits of any other service rendered on January 10, 2019.
4. 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)(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 29888 for CY 2019 = $5,699.59

The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 29888 for CY 2019 is 34.45%

Multiply these two = $1,963.51

1. Step 2 calculating the service portion of the procedure:
2. Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 29888 for CY 2019 is $3,696.68.
3. This number is divided by 2 = $1,848.34.
4. This number multiplied by the City Wage Index for Midland, TX of 0.8890 = $1,643.17.
5. The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,491.51.
6. The service portion is found by taking the geographically adjusted rate of $3,491.51 minus the device portion of $1,963.51 = $1,528.00.
7. Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment of 235% = -$3,590.80.
8. The MAR is determined by adding the sum of the reimbursement for the device portion and service portion =5,554.31. The insurance carrier paid $5,554.31. 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

		07/19/2019
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.