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
PARK CITIES SURGERY CENTER

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-19-4709-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 28, 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: $6,404.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The facility cannot be paid for a procedure that was done by the primary surgeon. Dr. Richard Levy did not bill for procedure code 23410 (Open Repair of Rotator Cuff Acute), therefore, the facility will not be paid for this code."

Response Submitted By: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 23410	$6,404.64	$0.00
	ASC CPT Code 29824	$0.00	$0.00
	HCPCS Code C1713	$0.00	$0.00
TOTAL		$4,938.07*	$0.00

*Requestor noted that an overpayment was made by insurance carrier.

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:
   - Previous gross recommended payment amount.
   - This code was not billed by the Primary Surgeon.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

Is the requestor due reimbursement for ASC services related to code 23410 rendered on March 6, 2019?

Findings

1. On the disputed date of service, the requestor billed $11,549.00 and was paid $0.00 for code 23410 based upon "This code was not billed by the Primary Surgeon," and "P12-Workers' compensation jurisdictional fee schedule adjustment."
2. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
3. To determine if the requestor is due additional reimbursement for ASC services, the division refers to the following statutes:
   - 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.

4. CPT code 23410 is described as "Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute."
5. A review of the Operative report finds the claimant underwent arthroscopic right shoulder surgery. The report does not support the level of service required for billing CPT code 23410. The division finds the requestor did not support billing CPT code 23410; therefore, 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

		7/25/2019
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.