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
GRAPEVINE SURGICARE PARTNERS

Respondent Name
TX ASSOC OF COUNTIES RMP

MFDR Tracking Number
M4-19-4971-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JULY 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2019 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $1,668.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was sent in as a request for reconsideration on 04/25/2019. The letter states the bill was underpaid by $4,082.35. An additional amount of $308.87 was paid under review 10417969 on 5/22/2019 on line 29888 LT. Check was issued on 5/24/2019 on check number 661158. The provider did not request separate reimbursement for implants billed; therefore allowance @235%. The bill was sent in as reconsideration again on 6/27/2019 stating the bill underpaid by $3773.48. The provider states code 29888 should be paid at $7949.49 and 29881 at $2831.21. The bill was denied for additional payment as properly reimbursed under review 10417969."

Response Submitted by: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2019	Ambulatory Surgical Care Services CPT Code 29888	$1,668.28	$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. The insurance carrier paid/denied/ reduced payment for the disputed services with the following claim adjustment codes:
   - P14-The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 193-Oriignal payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for ASC services related to CPT code 29888?

Findings

1. The fee guideline for ASC 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."
3. 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 29888 is described as "Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction."

   Per ADDENDUM AA, CPT code 29888 is a device intensive procedure.
5. The requestor did not request separate reimbursement for the implantables; therefore, Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) applies to this dispute.

   Division rule at 28 TAC §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

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 29888 for CY 2019 is $3,696.68.

  This number is divided by 2 = $1,848.34.

  This number multiplied by the City Wage Index for Grapevine, TX of 0.9703 = $1,793.44.

  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,641.78.

  The service portion is found by taking the geographically adjusted Medicare ASC rate of $3,641.78 minus the device portion of $1,963.51 =$1,678.27.

  Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment of 235% = $3,943.93.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $5,907.44.

The division finds the MAR for CPT code 29888 is $5,907.44. The insurance carrier paid $5,907.47. The division finds the requestor has been paid per the fee guideline; therefore, additional reimbursement is not due.

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

		08/22/2019
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.