TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THE CENTER FOR SPECIAL SURGERY @ TCA

Respondent Name
ACIG INSURANCE CO

MFDR Tracking Number
M4-19-5049-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JULY 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is our position that once the copy of the authorization letter is received and submitted to Corvel, TCSS claim for payment not be denied for 'timely filing' or 'appeal deadline passed'."

Amount in Dispute: $2,749.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "While ACIG feels its denial of payment was proper, in an effort to resolve this case and forego the additional time and expense associated with he continued litigation of this matter, ACIG has agreed to pay the disputed date of service. Accordingly, ACIG requests the Division dismiss this medical dispute. To aid in your review of this matter, ACIG has provided the attached explanation of benefit approving payment for the January 30, 2019 date of service."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 29881-LT	$2,749.37	$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 (DWC).

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:
   - P12-Workers' compensation jurisdictional fee schedule adj.

Issues

Is the requestor entitled to reimbursement for ASC services rendered on January 30, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $5,749.37 for ASC services rendered on January 30, 2019.
2. The respondent paid $2,749.38 + $48.06 = $2,797.44.
3. The fee guideline for ASC services is found in 28 TAC §134.402.
4. 28 TAC §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."
5. 28 TAC §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."
6. CPT code 29881 is described as "Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed."

   Per ADDENDUM AA, CPT code 29881 is a non-device intensive procedure.
7. The requestor did not request separate reimbursement for the implantables; therefore, DWC rule at 28 TAC §134.402(f)(2)(A)(i)(ii) applies to this dispute.
8. 28 TAC §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 ASC reimbursement for code 29881 CY 2019 is $1,256.79.

   The Medicare ASC reimbursement is divided by 2 = $628.39.

   This number multiplied by the City Wage Index for San Antonio, Texas of 0.8618= $541.54.

   Add these two together = $1,169.93.

   To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,749.33.

The respondent paid $2,797.44. The DWC finds the requestor is not due additional reimbursement.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/18/2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.