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
METROCREST SURGERY CENTER

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-19-5374-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
AUGUST 30, 2019

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: $640.88

RESPONDENT'S POSITION SUMMARY

"The Carrier has [paid a total of $7,263.86. Respondent stands by this payment amount. Requestor was reimbursed pursuant to the Medicare fee guidelines for the billed procedures."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 25390	$785.35	$0.00
	ASC CPT Code 29846	$0.00	$0.00
TOTAL		$640.88	$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 reduced/denied payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 593-the recommended allowance based on the value of surgical assistance performed by licensed non-physician.
   - 4063-Reimbursed is based on the physician fee schedule when a professional service was performed in the facility setting.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - W3-Additional payment made on appeal/reconsideration.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 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 rendered on February 27, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $640.88 for ASC services rendered on February 27, 2019.
2. The respondent contends that reimbursement of $7,635.68 was made per the fee guideline.
3. The fee guidelines for disputed services is found in 28 TAC §134.402.

   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.

   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.

   The disputed services are described as:

   - CPT code 25390 as "Osteoplasty, radius OR ulna; shortening."
   - CPT code 29846 as "Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement."

4. To determine the appropriate reimbursement for CPT codes 25390 and 29846 the DWC refers to 28 TAC §134.402(f).

   A. Per ADDENDUM AA, CPT codes 25390 is a device intensive procedure.

   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 25390 for CY 2019 = $5,606.42

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25390 for CY 2019 is 33.21%

  Multiply these two = $1,892.83

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 25390 for CY 2019 is $3,685.83.
  This number is divided by 2 = $1,842.91.
  This number multiplied by the City Wage Index for Carrollton, Texas of 0.9862 = $1,817.47.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,660.38.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,767.55.

  Multiply the service portion by the DWC payment adjustment of 235% = $4,153.74.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $6,046.57.

The DWC finds the MAR for CPT code 25390 is $6,046.57.

B. Per ADDENDUM AA, CPT code 29846 is a non-device intensive procedure.

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 29846 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 Carrollton, Texas of 0.9862= $619.71.

Add these two together = $1,248.10.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,933.03. This code is subject to multiple procedure rule discounting of 50% = $1,466.51.

The DWC finds the MAR for CPT code 29846 is $1,466.51

The DWC finds the MAR for the ASC services rendered on February 27, 2019 is $7,513.08. The respondent paid $7,635.68. 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

		10/10/2019
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.