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
SOUTH SHORE SURGICENTER

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-20-1748-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
MARCH 17, 2020

REQUESTOR'S POSITION SUMMARY

"TASB allowed the CPT code 27792 at $4338.79. According to our calculations based on TDI guidelines the carrier should have allowed this CPT code at $8384.92. TASB shorted our facility $4046.13. TASB did reimburse us correctly on the hardware used."

Amount in Dispute: $4,046.13

RESPONDENT'S POSITION SUMMARY

"The Fund has made total payment of $5152.17 based on the maximum allowable reimbursement. This reimbursement amount includes payment made for CPT code 27792 and implants billed with HCPCS code C1713."

Response Submitted By: TASB Risk Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 27792	$4,046.13	$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 (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 TAC §133.10, sets out the required health care provider billing procedures.
4. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 193-Original 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 due additional reimbursement for ASC services rendered on December 20, 2019?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $4,046.13 for ASC services related to CPT code 27792 rendered on December 20, 2019.

The requestor wrote, "TASB allowed the CPT code 27792 at $4338.79. According to our calculations based on TDI guidelines the carrier should have allowed this CPT code at $8384.92. TASB shorted our facility $4046.13. TASB did reimburse us correctly on the hardware used."

The respondent wrote, "The Fund has made total payment of $5152.17 based on the maximum allowable reimbursement. This reimbursement amount includes payment made for CPT code 27792 and implants billed with HCPCS code C1713."

The fee guideline for ASC services is found at 28 TAC §134.402.

Per ADDENDUM AA, CPT codes 27792 is a device intensive procedure.

28 TAC §134.402(f)(2)(B)(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: (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent.

A. CPT Code 27792:

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 27792 for CY 2019 = $5,699.59

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 22792 for CY 2019 is 30.98%

  Multiply these two = $1,765.73

- Step 2 calculating the service portion of the procedure:

Per Addendum AA, the Medicare ASC reimbursement rate for code 22792 for CY 2019 is $3,568.05.

This number is divided by 2 = $1,784.02.

This number multiplied by the City Wage Index for League City, Texas of 0.9812 = $1,750.48.

The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,534.50.

The service portion is found by taking the geographically adjusted rate minus the device portion = $1,768.77.

Multiply the service portion by the DWC payment adjustment of 235% = $4,156.62.

The DWC finds the MAR for CPT code 27792 is $4,156.62. The respondent paid $4,338.79. Based upon this payment, 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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/07/2020 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 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 with the DWC. **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.