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
M4-20-2321-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MAY 18, 2020

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."

Amount in Dispute: $4,938.07

RESPONDENT'S POSITION SUMMARY

"The review determined that the provider is not due additional money."

Response Submitted By: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 23410	$6,404.64	$0.00
	ASC Services for CPT Code 29824	$0.00	$0.00
	ASC Services for HCPCS Codes C1713	$0.00	$0.00
TOTAL		$4,938.07	$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. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - 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.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor due additional reimbursement ASC services rendered on December 11, 2019?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $4,938.07 for ASC services rendered on December 11, 2019.

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

A. CPT Code 23410

The respondent denied reimbursement for CPT code 23410 based upon "16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

28 TAC §134.402(b)(6) states, "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.

CPT code 23410 is described as "Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute."

A review of the Operative Report finds the claimant underwent an arthroscopic shoulder surgery not an open surgery; therefore, the respondent's denial of payment is supported.

B. CPT Code 29824

The respondent paid $2,933.11 for CPT code 29824 based upon the fee guideline.

The requestor did not seek separate reimbursement for the implantables; therefore, 28 TAC §134.402(f)(1)(A) applies to this dispute.

28 TAC §134.402(f)(1)(A) 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.

Per Addendum AA code 29824 is a non-device intensive procedure.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 29824 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 University Park, Texas of 0.9862= $619.72.

Add these two together = $1,248.11.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,933.06.

The DWC finds the total due for ASC services rendered on December 11, 2019 is $2,933.06. The respondent paid $2,933.11. As a result, additional reimbursement is not recommended.

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 Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

________________________	________________________	06/16/2020
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 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.