



# 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**

BAYLOR SURGICARE AT MANSFIELD

**Respondent Name**

HARTFORD FIRE INSURANCE CO

**MFDR Tracking Number**

M4-20-2826-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

JULY 31, 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:** \$1,454.79

#### RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 29827	\$0.00	\$0.00
	ASC Services for CPT Code 29824	\$1,454.79	\$1,454.79
	ASC Services for HCPCS Codes C1713	\$0.00	\$0.00
TOTAL		\$1,454.79	\$1,454.79

#### 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:
  - 309-Charge for this procedure exceeds fee schedule allowance.
  - P12-Workers' compensation jurisdictional fee schedule adjustment.
  - W3-Additional payment made on appeal/reconsideration.
  - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 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.
  - 6766-Specialty bill audit/expert code review involving the application of code auditing rules and edits based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, and coding guidelines developed by national societies and prevailing industry standards and coding practices.
  - 5962-Per CPT Changes and Insider's View 2002 and AAOS Bulletin April 2004, at least 8mm or 1 cm of the distal clavicle must be removed to report this service.

## **Issues**

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

## **Findings**

1. The Austin carrier representative for Hartford Fire Insurance Co is Burns Anderson Jury & Brenner, LLP. Burns Anderson Jury & Brenner, LLP received a copy of this medical fee dispute on August 4, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution in the amount of \$1,454.79 for ASC services rendered on December 11, 2019.
3. The respondent denied reimbursement for CPT code 29824 based upon reason codes 6766 and 5962 listed above.

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

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."

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 DWC finds the respondent did not support the denial based upon "coding guidelines developed by national societies and prevailing industry standards and coding practices," and "AAOS Bulletin April 2004" complied with CMS's payment policies.

4. The respondent also denied reimbursement for CPT code 29824 based upon reason codes P12 and 309.

On the disputed date of service, the requestor billed CPT codes 29827, 29824, 29826 and C1713. Per CMS's CCI edits, CPT code 29824 is not unbundled or has a coding conflict with any of the other codes.

5. CPT code 29824 is described as "Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)."

A review of the Operative report supports billed procedure; therefore, reimbursement is recommended.

6. 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 = \$628.40.

This number multiplied by the City Wage Index for Mansfield, Texas of 0.9703= \$609.73.

Add these two together = \$1,238.13.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = \$2,909.61. CPT Code 29824 is subject to multiple procedure discounting of 50% = \$1,454.79.

### **Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$1,454.79.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$1,454.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
10/12/2020  
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.**