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
THE CENTER FOR SPECIAL SURGERY

Respondent Name
VALLEY FORGE INSURANCE CO

MFDR Tracking Number
M4-21-0683-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
DECEMBER 17, 2020

REQUESTOR'S POSITION SUMMARY

"CAN has not processed our claim for services rendered as indicated by Texas Workers' Compensation fee schedule. We have appealed this claim with CAN maintaining their original decision."

Amount in Dispute: $2,731.98

RESPONDENT'S POSITION SUMMARY

"Carrier maintains any and all denials as represented in the referenced EORs."

Respondent's Supplemental Position Summary: "The bill was audited and the Explanation of Review resulted in the recommended allowance of $5,350.40…Carrier respectfully requests an order of no additional reimbursement due as the bills were properly processed in compliance with the Texas Labor Code and the Administrative Rules"

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 28485	$2,731.98	$0.00
	ASC Services for HCPCS Code C1713	$0.00	$0.00
TOTAL		$2,731.98	$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 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 codes:
   - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 295-Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on June 23, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,731.98 for ASC services rendered on June 23, 2020.
2. The respondent contends that payment of $5,350.40 for CPT code 28485 was based upon the fee guideline, and additional reimbursement is not due.
3. The fee guidelines for disputed services is found in 28 TAC §134.402.

   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.

   A. Per ADDENDUM AA, CPT codes 28485 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 28485 for CY 2020 = $5,981.95.

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 28485 for CY 2020 is 34.09%

Multiply these two = $2,039.25

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 28485 for CY 2020 is $3,731.89.
  This number is divided by 2 = $1,865.95.
  This number multiplied by the City Wage Index for San Antonio, Texas of 0.8432 = $1,573.36.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,439.31.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,400.06.

  Multiply the service portion by the DWC payment adjustment of 235% = $3,290.15.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $5,329.40.

The DWC finds the MAR for CPT code 28485 is $5,329.40. The respondent paid $5,350.40. 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/21/2021 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.