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
GRAPEVINE SURGICARE

Respondent Name
GENERAL MOTORS LLC

MFDR Tracking Number
M4-21-1345-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
APRIL 5, 2021

REQUESTOR'S POSITION SUMMARY

"At this time we are requesting that this claim paid in accordance with the 2020 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $287.39

RESPONDENT'S POSITION SUMMARY

"As reflected in the attached EOB's…properly reimbursed Grapevine Surgicare in accordance with the Texas Fee Schedule and Guidelines."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 29827	$2,274.83	$0.00
	ASC CPT Code 29822	$521.87	$0.00
	HCPCS Code C1713	$0.00	$0.00
TOTAL		$287.39	$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:
   - 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.
   - W3-Additional payment made on appeal/reconsideration

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on September 9, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $287.39 for ASC services rendered on September 9, 2020.
2. The respondent contends that no additional reimbursement is due because payment of $7,319.30 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 service are described as:

   - 29827- Arthroscopy, shoulder, surgical; with rotator cuff repair.
   - 29822- Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies]).
   - C1713- Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable).

4. Per ADDENDUM AA, CPT code 29827 and 29822 are non-device intensive procedure. The requestor sought separate reimbursement for the implantables.

   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: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-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 Medicare ASC facility reimbursement amount multiplied by 153 percent.

The following formula was used to calculate the MAR:

A. 29827

The Medicare ASC reimbursement for code 29827 CY 2020 is $2,803.36.

The Medicare ASC reimbursement is divided by 2 = $1,401.68.

This number multiplied by the City Wage Index for Grapevine, Texas of 0.9792= $1,372.53.

Add these two together = $2,774.21.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $4,244.53.

B. 29822

The Medicare ASC reimbursement for code 29822 CY 2020 is $1,286.26.

The Medicare ASC reimbursement is divided by 2 = $643.13.

This number multiplied by the City Wage Index for Grapevine, Texas of 0.9792= $629.75.

Add these two together = $1,272.88.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $1,947.51. This code is subject to multiple procedure discounting of 50% = $973.75.

C. C1713

A review of the submitted documentation finds a copy of a Patient Charges report that lists ACL implantables. The claimant underwent shoulder surgery not knee surgery. The DWC finds this list does not correspond to the implantables itemized as AR-2324BCCT listed on the Arthrex Sales Order.

The submitted invoice supports a cost of $1,344.00. Per 28 TAC §134.402(f)(1)(B)(i), the requestor is due $1,478.40 for the implants.

Based upon the submitted documentation and the fee guideline, the requestor is due $6,696.68 for ASC services rendered on September 9, 2020. The respondent paid $7,319.30. 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

		May 5, 2021
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 TAC §141.1(d).

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