TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
North Garland Surgery Center

Respondent Name
City of Garland

MFDR Tracking Number
M4-22-0471-01

Carrier's Austin Representative
Box Number 53

DWC Date Received
November 4, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 12, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 29888	$2,415.78	$0.00
	ASC CPT Code 29883	$0.00	$0.00
	ASC CPT Code 64445	$0.00	$0.00
	ASC CPT Code 64447	$0.00	$0.00
	ASC CPT Code 76942	$1.10	$0.00
	HCPCS Code C1713	$876.80	$0.00
	HCPCS Code C9290	$44.57	$0.00
	Total	$2,425.88	$0.00

Requestor's Position

"At this time we are requesting that this claim paid in accordance with the 2018 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $2,425.88

Respondent's Position

"The health care provider was initially reimbursed $5054.68 for codes 29888, 29883, 64445, 64447 and C9290. No allowance was recommended for C1713 as the healthcare provider did

not submit cost invoice(s) for their implantables with their original bill. No allowance recommended for 76942 as this code is status N and not separately payable…An additional allowance of $8765.87 was recommended…for C1713 and $88.77 for C9290."

Response Submitted By: Novacare, LLC

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, sets out the fee guidelines for ASC services.
3. 28 TAC §134.203, sets out the fee guidelines for non-facility services

Denial Reasons

The insurance carrier reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 86-Service performed was distinct or independent from other service performed on the same day.
- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 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.
- 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 4915-The charge for the service represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- W3-Bill is a reconsideration or appeal.
- 2005-No additional reimbursement allowed after review of appeal/reconsideration.

- 2008-Additional payment made on appeal/reconsideration.

1. Is North Garland Surgery Center entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,425.88 for ASC services rendered on May 12, 2021.

   The respondent contends that additional reimbursement is not due because payment of $13,820.55 was made per the fee guideline.

   The fee guidelines for disputed services is found in 28 TAC §134.402.

   A. Per Addendum AA, CPT codes 29888 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.

   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 29888 for CY 2021 = $6,264.95.

     The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 29888 for CY 2021 is 38.24%

     Multiply these two = $2,395.72.

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare ASC reimbursement rate for code 29888 for CY 2021 is $4,035.90.

     This number is divided by 2 = $2,017.95

     This number multiplied by the City Wage Index for Garland, Texas of 0.9744 = $1,966.29.

The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,984.24.

The service portion is found by taking the geographically adjusted rate minus the device portion = $1,588.52.

Multiply the service portion by the DWC payment adjustment of 235% = $3,733.02.

The requestor sought separate reimbursement for the implantables and will be addressed below.

The DWC finds the MAR for CPT code 29888 is $3,733.02.

B. Per Addendum AA, CPT code 29883 is a non-device intensive procedure.

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:

The Medicare ASC reimbursement for code 29883 CY 2021 is $1,328.25.

The Medicare ASC reimbursement is divided by 2 = $664.13.

This number multiplied by the City Wage Index for Garland, Texas of 0.9744= $647.12.

Add these two together = $1,311.25.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $2,006.22. This code is subject to multiple procedure rule discounting of 50% = $1,003.11.

The DWC finds the MAR for CPT code 29883 is $1,003.11

C. Per Addendum AA, CPT codes 64445 and 64447 are Payment Indicator P3 codes.

Addendum DDI defines payment indicator P3 as “Office-based surgical procedure added to

ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs."

28 TAC §134.402(h) states,

> For medical services provided in an ASC, but not addressed in the Medicare payment policies as outlined in subsection (f) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

28 TAC §134.203(c)(1)(2) states,

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
>
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) DWC conversion factor in 2007.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

The 2021 DWC Conversion Factor is 76.76

The 2021 Medicare Conversion Factor is 34.8931

Both 64445 and 64447 are subject to multiple procedure discounting of 50%.

Using the above formula, the DWC finds the MAR is:

Code	Units	Medicare Payment	MAR or §134.203 (h) Lesser of MAR billed amount
64445	1	$133.55	$293.79 X 50% = $146.90
64447	1	$92.89	$204.35 X 50% = $102.17

D. Per Addendum AA, CPT code 76942 is not listed as an ASC Covered Surgical Procedures for CY 2021.

28 TAC §134.402(i) states,

If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:

(1) The agreement may occur before, or during, preauthorization.

(2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

(3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) any other provisions of the agreement; and

(C) names, titles and signatures of both parties with dates.

(4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

The requestor did not submit any documentation that an agreement was reached prior or during preauthorization for code 76942. The dispute packet did not contain a signed copy of an agreement, that identified the parties to the agreement, or the amount of reimbursement as required by 28 TAC §134.402(i) for code 76942. As a result, reimbursement is not recommended.

E. The requestor is seeking separate reimbursement for the implantables billed with HCPCS codes C1713 and C9290.

As stated above, per 28 TAC §134.402 (f)(1)(B) and (f)(2)(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."

Per the Operative Report the following implants were used in the procedure:

Implant Name	No of Units	Cost	MAR
Tight Rope	1	$529.00	$581.90
PEEK interference screw 8mm	1	$422.00	$464.20
Fiber Tape	Cost Information was not submitted		
Swivel Lock	1	$1,036.00	$1,139.60

Fiber Stictch Arthrex	2	$708.00	$778.80 X2 = $1,557.60
TOTAL			$3,743.30

The DWC finds the MAR for the ASC services rendered on May 12, 2021 is $8,728.50. The respondent paid $13,820.55. The DWC finds the requestor is not due additional reimbursement.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/01/2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.