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

General Information

Requestor Name
Metrocrest Surgery Center, LP

Respondent Name
LM Insurance Corp.

MFDR Tracking Number
M4-22-0681-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
December 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2021	ASC Services CPT Code 29855	$4,465.66	$0.00

Requestor's Position

At this time we are requesting that this claim paid in accordance with the 2021 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers.

Amount in Dispute: $4,465.66

Respondent's Position

We have again reviewed payment for the services of September 2, 2021 by MetroCrest Surgery Center and determined that reimbursement was issued according to the guidelines provided by the Texas Medical Fee Schedule. No additional payment is due

Response Submitted by: Liberty Mutual Insurance

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.

Denial Reasons

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

- 197 – No description of code provided
- 5876 – According to the Texas Division of Workers Compensation Rules Effective May 1, 2007, all medical treatment provided to workers compensation patients in the State of Texas must follow the Official Disability Guidelines (ODG). The services provided are outside the ODG Guidelines and no pre authorization was requested.
- P12 – No description of code provided
- 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Is LM Insurance Corporation's denial based on preauthorization supported?

2. Is Metrocrest Surgery Center, LP entitled to additional reimbursement?

Findings

1. Metrocrest Surgery Center, LP is seeking additional reimbursement for ambulatory surgical services, CPT code 29855, performed September 2, 2021. Per explanation of benefits dated October 8, 2021, LM Insurance Corp. denied this code based on preauthorization requirements.

   Per explanation of benefits dated November 19, 2021, the insurance carrier did not maintain this denial and reimbursed $5,842.15. DWC concludes that the denial for preauthorization is not supported.

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

   Per Addendum AA, CPT codes 29855 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 29855 for CY 2021 = $6,264.95.

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 29855 for CY 2021 is 53.58%.

  Multiply these two = **$3,356.76**.

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 29855 for CY 2021 is $4,443.17.

  This number is divided by 2 = $2,221.59.

  This number multiplied by the City Wage Index for Carrollton, Texas of 0.9744 = $2,164.72.

  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$4,386.31.

  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,029.55.

  Multiply the service portion by the DWC payment adjustment of 235% = **$2,419.44**.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = **$5,776.20**.

The DWC finds the MAR for the ASC services rendered on September 2, 2021, is $5,776.20. The respondent paid $5,842.15. The DWC concludes that no additional reimbursement is recommended.

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

		January 31, 2022
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 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, opción 3 o correo electronico CompConnection@tdi.texas.gov.