

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Physicians Surgical Center

Respondent Name

Texas Mutual Insurance Co.

MFDR Tracking Number

M4-22-1198-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

February 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 29888	\$5,258.10	\$0.00
	ASC CPT Code 29882	\$0.00	\$0.00
	ASC CPT Code 29881	\$0.00	\$0.00
	HCPCS Code C1713	\$0.00	\$0.00
Total		\$5,258.10	\$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: \$5,258.10

Respondent's Position

The Austin carrier representative for Texas Mutual Insurance Company is Texas Mutual Insurance Company. Texas Mutual Insurance Company received a copy of this medical fee dispute on February 22, 2022. 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).

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:

- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4-No additional reimbursement allowed after reconsideration.
- 763-Paid per ASC FG at 235%; implants not applicable or separate reimbursement (w/signed cert) not requested: Rule 134.402(G).

Issues

1. Is Physicians Surgical Center entitled to additional reimbursement for CPT code 29888?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$5,258.10 for ASC services related to CPT code 29888 rendered on September 2, 2021.

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 \$4,035.99.

This number is divided by 2 = \$2,018.00.

This number multiplied by the City Wage Index for Fort Worth, Texas of 0.9697 = \$1,956.85.

The sum of these two is the geographically adjusted Medicare ASC reimbursement = \$3,974.85.

The service portion is found by taking the geographically adjusted rate minus the device portion = \$1,579.13.

Multiply the service portion by the DWC payment adjustment of 235% = \$3,710.95.

The DWC finds the MAR for CPT code 29888 is \$3,710.95. The respondent paid \$4,082.77.

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

May 13, 2022

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 prefieres 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.