2021

TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Physicians Surgical Center

Respondent Name
Hanover Insurance Co

MFDR Tracking Number
M4-22-1347-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
March 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 15, 2021	29888	$1998.74	$0.00
April 15, 2021	29881	$0.00	$0.00
April 15, 2021	C1762	$0.00	$0.00
April 15, 2021	C1713	$0.00	$0.00
	Total	$1998.74	$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."

Amount in Dispute: $1,998.73

Respondent's Position

"After re-review of the submitted documentation it has been determined that the bill was reviewed appropriately to the Texas Workers Compensation fee schedule, more specifically, the payment surrounding service code 29888."

Response submitted by: Medata Service Operations

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 ambulatory surgical centers.

Denial Reasons

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

- P12 – The charge for the procedure exceeds the amount indicated in the fee schedule
- W3 - Additional payment made on appeal/reconsideration
- SA (P12) – Payment of multiple surgery procedures rendered in an Ambulatory Surgery Center is limited to the following. 100 percent of the payment amount for the surgery in the highest ASC payment group Each additional procedure is paid at 50 percent of the maximum payment for the ASC payment group
- ZC (P12) – Your billing has been paid in accordance with the Inpatient Hospital Fee Schedule or the Outpatient Fee Schedule.

Issues

1. Is the insurance carriers' reduction supported?

2. What rule applies for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement of CPT Code 29888 rendered as part of a surgery performed in an Ambulatory Surgical Center on April 15, 2021. The insurance carrier reduced the amount paid based on the fee schedule.

   DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service. The applicable fee guideline and Medicare payment policy is shown below.

2. The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center

Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.

DWC Rule 28 TAC §134.402 (f) states in pertinent part 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.

The requestor sought separate reimbursement of implants. DWC Rule 28 TAC §134.402 (f)(2)(B)(i)(ii) states in pertinent part, if an ASC facility requests separate reimbursement for an implantable, reimbursement for the service intensive procedure shall be the sum of the lesser of the manufacturer's invoice amount or the net amount plus 10 percent or $1,000 per billed item add-on not to exceed $2,000 and the ASC service portion multiplied by 235 percent.

The following formula was used to calculate the MAR:

Review of the applicable Addenda AA ASC Covered Surgical Procedures found the Code 29888 has a payment indicator of J8. This is a device intensive procedure paid at an adjusted rate. 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 xxx for date of service = $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 date of service is $4,035.99.
- This number is divided by 2 = $2,018.00.
- This number multiplied by the CBSA 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 = $3,974.85 - $2,395.72 = $1,579.13.

- Multiply the service portion by the DWC payment adjustment of 235% = $3,711.00.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the service portion and the implant net invoice plus 10 percent not to exceed $2,000 in add-ons.

- Review of the submitted documentation found the "Implant Cost Certification" did not contain a signature or date.

  DWC Rule 28 TAC §134.402(g)(1)(B) states in pertinent part, the facility or surgical implant provider requesting reimbursement for the implantable shall include with the billing a certification that the amount billed represents the actual cost and shall include the sentence, "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of by knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts.

  No additional payment can be 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

		May 23, 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.