Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PARK CENTRAL SURGICAL CENTER
122000 PARK CENTRAL DIVE SUITE 300
DALLAS TX 75251

Respondent Name
TRAVELERS INDEMNITY CO OF CONN

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-09-6956-01

MFDR Date Received
MARCH 13, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have tried three times to get Travelers to pay or claim correctly. We wrote two requests for reconsideration which generated two follow-up payments. However, our claim is still underpaid by $167.79 according to the TWCC rates. Please have them remit this amount."

Amount in Dispute: $167.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reimbursed the Provider $1,174.81 for CPT code 29877, which represents the Medical Fee Guideline Maximum Allowable Reimbursement of $1,342.60 minus the Provider's contracted discount of $167.79. Consequently, purusuant to the contract between the Provicer and the Carrier, the Provider has been properly reimbursed for this procedure."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 6, 2008	ASC Services for CPT Code 29877-59-RT	$167.79	$165.89

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective December 30, 2007, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - A2-Contractual adjustment, any reduction is in accordance with Focus/Aetna Worker's Comp Access LLC.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The services in dispute were reduced in part with the explanation "A2-Contractual adjustment, any reduction is in accordance with Focus/Aetna Worker's Comp Access LLC." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier Travelers Indemnity Co Of Conn. and Park Central Surgical Center prior to the services being rendered; therefore the disputed services will be reviewed per applicable Division rules and guidelines.

2. 28 Texas Administrative Code §134.402(b) states "For coding, billing, reporting, and reimbursement of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   28 Texas Administrative Code §134.402(c) states "To determine the maximum allowable reimbursement (MAR) for a particular service, system participants shall apply the Medicare payment policies for these services and the Medicare ASC reimbursement amount multiplies by 213.3%."

   CPT Code 29877-Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty) is listed in ASC payment group 4.

   Based upon the submitted medical bill the requestor is located in Dallas, TX in Dallas County. Dallas County is located in the reasonable charge locality 11.

   The Medicare ASC rate for ASC payment group 4 in locality 11 is $629.44.

   To determine the MAR the Medicare ASC reimbursement of $629.44 is multiplied by 213.3% = $1,340.70. The respondent paid $1,174.81. The difference between amount paid and MAR is $165.89; this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $165.89.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $165.89 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/20/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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