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
ROC ASC LLP

Respondent Name
TPCIGA FOR ULLICO CASUALTY CO

MFDR Tracking Number
M4-12-3678-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
AUGUST 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are in receipt of the benefit payment of 2604.53…It is our understanding that benefits were significantly reduced."

Amount in Dispute: $4,011.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2011	Ambulatory Surgical Care Services CPT Code 29827-RT	$2,210.15	$2,171.30
	Ambulatory Surgical Care Services CPT Code 29826-RT	$1,801.15	$1,781.72
TOTAL		$4,011.30	$3,953.02

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, effective June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 222-Charge exceeds Fee Schedule allowance.
   - W1-Workers compensation state fee schedule adjustment.
   - 647-Reimbursement based on multiple endoscopy procedure policy.
   - 59-Charges are adjusted based on multiple surgery rules or concurrent anesthesia rule.

- 18-Duplicate claim/service.
- 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- Notes: Bill reviewed correctly. No additional allowance is recommended.

3. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 5, 2012. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Is the requestor entitled to additional reimbursement for CPT code 29827-RT?
2. Is the requestor entitled to additional reimbursement for CPT code 29826-RT?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   CPT code 29827 is defined as "Arthroscopy, shoulder, surgical; with rotator cuff repair."

   28 Texas Administrative Code §134.402(f)(1)(A) 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: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   According to Addendum AA, CPT code 29827 is a non-device intensive procedure.

   The City Wage Index for Houston, TX is 0.9824.

   The Medicare fully implemented ASC reimbursement for code 298727 CY 2011 is $1,876.83.

   To determine the geographically adjusted Medicare ASC reimbursement for code 29827:

   The Medicare fully implemented ASC reimbursement rate of $1,876.83 is divided by 2 = $938.41

   This number multiplied by the City Wage Index is $938.41 X 0.9824 = $921.89.

   Add these two together $938.41 + $921.89 = $1,860.30.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

   $1,860.30 X 235% = $4,371.70. The respondent paid $2,200.40. The difference between the MAR and amount paid is an overpayment of $2,171.30.

2. CPT code 29826 is defined as "Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)."

   The Medicare fully implemented ASC reimbursement for code 29826 CY 2011 is $1,876.83.

   Using the above formula the MAR is $4,371.70; however, CPT code 29826 is subject to multiple procedure rule discounting. According to the Medicare ASC manual, "When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are

furnished in the same session." $4,371.70 X 50% = $2,185.85. The respondent paid $404.13. The difference between the MAR and amount paid is $1,781.72.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,953.02.

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 $3,953.02 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/25/2014
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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