



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Physicians Surgical Center

**Respondent Name**

Travelers Indemnity Co

**MFDR Tracking Number**

M4-14-0833-01

**Carrier's Austin Representative**

Box Number 05

**MFDR Date Received**

November 13, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We submitted a clean claim with all required documentation requesting separate reimbursement for our implants and the carrier ignored that request."

**Amount in Dispute:** \$4,774.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier has reviewed the calculations and determined the Provider is entitled to additional reimbursement in the amount of \$562.20. The carrier denied that the Provider is entitled to additional reimbursement in the amount sought by the Provider on the Table of Disputed Services."

**Response Submitted by:** Travelers

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 2, 2013	L8699	\$4,774.00	\$140.65

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402 sets out the guidelines for reimbursement for services provided in ambulatory surgical centers.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97 – Charge for this procedure exceeds Medicare ASC schedule allowance
  - 983 – Charge for this procedure exceeds Medicare ASC schedule allowance
  - 851 – Charge exceeds Mult proc rules
  - 243 – Allowance included in another svc

**Issues**

1. Did the requestor request separate reimbursement for implantables?
2. Is the requestor entitled to reimbursement?

**Findings**

1. Review of the submitted medical bill finds separate reimbursement was requested. 28 Texas Administrative Code §134.402(f) 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 (date of service), or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-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 Medicare ASC facility reimbursement amount multiplied by 153 percent.” Therefore, the disputed services will be calculated as follows:

Date of Service	Submitted Code	Amount Billed	Units	Implantable Description	Invoice Amount	Rule 134.402 (f) MAR (Geographically adjusted Medicare ASC reimbursement)
May 2, 2013	29888	13,078.00	1	n/a	n/a	ASC reimbursement divided by 2 multiplied by CBSA city wage index, sum of these two, multiplied by 153% or $3289.61 \div 2 = 1644.81 \times 0.9525 = 1566.68$ $1644.81 + 1566.68 = 3211.49 \times 153\% = 4,913.58$
May 2, 2013	29881	10,583.00	1	n/a	n/a	$1184.89 \div 50\%$ (Medicare Multiple Procedure Discount applies) = $592.45 \div 2 = 296.23 \times 0.9525 = 282.16$ $296.23 + 282.16 = 578.39 \times 153\% = 884.94$
May 2, 2013	29875	4,218.50	1	n/a	n/a	$1184.89 \div 50\%$ (Medicare Multiple Procedure Discount applies) = $592.45 \div 2 = 296.23 \times 0.9525 = 282.16$ $296.23 + 282.16 = 578.39 \times 153\% = 884.94$
May 2, 2013	L8699	1,360.00	1	ACL Disposable Kit	495.00	Rule 134.402(b)(5) not met as item does meet the definition of “implantable”. Documentation does not support item was implanted, embedded, inserted, or otherwise applied
				Screw Milagro Advance 9.23	495.00	Net amount plus 10 percent or $495.00 + 49.50 = 544.50$
				Rigid Fix	495.00	$495.00 + 49.50 = 544.50$
May 2, 2013	L8699	2,900.00	1	Patellar Ligament	2,900.00	$2900.00 + 290.00 = 3,190.00$
May 2, 2013	L8699	80.00	1	S&N Dyonics 4.5mm bonecutter	80.00	Rule 134.402(b)(5) not met as item does meet the definition of “implantable”. Documentation does not support item was implanted, embedded, inserted, or otherwise applied
	TOTAL	\$32,219.50			\$4,340.00	10,962.46

2. The total maximum allowable reimbursement for the services in dispute if \$10,962.46. The carrier previously paid \$10,821.81. The remaining balance of \$140.65 is recommended.

**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 \$140.65.

**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 \$140.65 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

\_\_\_\_\_  
Date

July , 2014

***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.**