



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

North Garland Surgery Center

Respondent Name

Travelers Indemnity Co

MFDR Tracking Number

M4-14-1080-01

Carrier's Austin Representative Box

Box Number 05

MFDR Date Received

December 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2013 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: \$4,409.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With the supplements reimbursement now issued, the Carrier contends the Provider is not entitled to additional reimbursement."

Respondent: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2013	29846, 25390, L8699, L8699	\$4,409.07	\$0.00

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 reimbursement guidelines for medical services, charges and payments.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 78 – Charges exceeds mult surgery rates
 - 16 – Reimbursement is based on the physician fee schedule when a professional service was performed in

Issues

- What is the applicable rule to calculate reimbursement?
- Is the requestor entitled to reimbursement?

Findings

1. 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 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; or
 - (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. ...

Review of the submitted documentation finds a request for implantables was made and considered by the carrier. The services in dispute will be calculated at the Medicare ASC Facility reimbursement amount multiplied by 153% or

Submitted Procedure Code	National Reimbursement from Addendum AA	Statistical Area Number	Wage Index for ASC	Divide National Reimbursement by 2	Multiply by National Wage Index	Add to National Reimbursement Sum	Medicare Adjusted ASC Reimbursement	Total MAR
29846	1184.89 x 50% (Mx procedure discounting) = 592.45	19124 Dallas TX	0.9844	592.45 ÷ 2 = 296.25	296.25 x 0.9844 = 291.63	296.25 + 291.63 = \$587.88	587.88	587.53 x 153% = 899.46
25390	1928.93	19124 Dallas TX	0.9844	1928.93 ÷ 2 = 964.47	964.47 x 0.9844 = 949.42	964.47 + 949.42 = 1,913.89	1,913.89	1913.89 x 153% = 2928.25
							Total	\$3,827.71

Submitted Code	Amount billed	Units	Implantable Description	Invoice Amount	Did documentation support item met the definition of “implantable”	Implants Maximum allowable reimbursement
L8699	2181.94	1	27mm 2cp ulnaostentomy plate TI	1,159.72	Yes	Net amount plus 10% or 1,159.72 + 115.97 = 1,275.69
		3	14mm x 2.7mm cortex screw	114.03	Yes	Net amount plus 10% or 38.01 + 3.80 = 41.81 x 3 = 125.43
		2	16mm x 2.7mm TI cortex screw	76.02	No	n/a
		1	18mm x 2.7mm Ti lock & screw	38.01	No	n/a
		1	14 mm x 2.7 Ti locking screw	120.92	No	n/a
		2	16mm x 2.7 mm Ti lock screw	241.84	Yes	Net amount plus 10% or 241.84 + 24.18 = \$266.02
		3	2.0mm drill tip K-wire	128.76	Yes	Net amount plus 10% or 42.95 + 4.30 = 47.22 x 3 = 141.66
		1	2.7 mm drill bit	63.74	No	Rule 134.402(b)(5) not met as item does not meet the definition of “implantable”. Documentation does not support item was implanted, embedded, inserted, or otherwise applied
		1	2.0 mm drill bit	107.38		

		1	2.00 mm drill bit w/ depth	131.23	No	Rule 134.402(b)(5) not met as item does not meet the definition of "implantable". Documentation does not support item was implanted, embedded, inserted, or otherwise applied
L8699	244.83	1	Saw blade	244.83	No	Rule 134.402(b)(5) not met as item does not meet the definition of "implantable". Documentation does not support item was implanted, embedded, inserted, or otherwise applied
			Total	\$2,426.48 (Invoice shows 2,426.57)		\$1,808.80

2. The total allowable for the disputed services is \$5,636.51. The carrier paid \$5,667.25. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 8, 2015
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.