TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS SURGICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-18-1288-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
DECEMBER 29, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2017 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $119.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester bill code C1713 for implants. ASC Addendum BB…indicates C1713 has payment indicator N1 with no payment rate. No additional payment is due ."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2017	Ambulatory Surgical Care for CPT Code 24685	$0.00	$0.00
	Ambulatory Surgical Care for HCPCS Code C1713	$119.88	$0.00
Total		$119.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-97-the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 305-The implant is included in this billing and is reimbursed at the higher percentage calculation.
   - 225-Needing clarification of type and number of screws used during this procedure.
   - 350, CAC-W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - 724-No additional payment after a reconsideration of services.
   - 725-Approved non network provider for Texas Star Network claimant per Rule 1305.153(C).
   - 763-Paid per ASC FG at 235%: Implants not applicable of separate reimbursement (w/signed cert) not requested; Rule 134.402(G).

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?

2. Does code C1713 meet the definition of implantable per 28 Texas Administrative Code §134.402 (a) (5)?

3. Is the respondent's denial of payment supported for code C1713?

Findings

1. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

2. Per the Table of Disputed Services, the requestor is seeking reimbursement of $119.88 for code C1713.

   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, including the following paragraphs."

   Code C1713 is described as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

   The respondent denied reimbursement for code C1713based upon "CAC-97-the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated; 217-The value of this procedure is included in the value of another procedure performed on this date; and 305-The implant is included in this billing and is reimbursed at the higher percentage calculation."

   Per 28 Texas Administrative Code §134.402 (a) (5), "Implantable" means an object or device that is surgically:
   (A) implanted,
   (B) embedded,
   (C) inserted,
   (D) or otherwise applied, and
   (E) related equipment necessary to operate, program, and recharge the implantable."

   The physician wrote in the operative report, "A Synthes olecranon plate was affixed with locking and nonlocking screws."

   The division finds that the Synthes olecranon plate, and locking and nonlocking screws used in the procedure supports the definition of implantable per 28 Texas Administrative Code §134.402 (a)(5).

3. Section 413.011(b) of the Texas Labor Code states "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account

economic indicators in health care and the requirements of Subsection (d).The commissioner shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c)and commissioner rules. This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."

28 Texas Administrative Code §134.402's preamble states "The Division is adopting minimal modifications to Medicare's reimbursement methodology to reflect use of separate reimbursement for surgically implanted devices in non-device intensive procedures to ensure injured employees have access to care, including surgery where surgically implanted devices are medically necessary."

According to *Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2017 (Including Ancillary Services for Which Payment is Packaged*), HCPCS Code C1713 has a payment status indicator of "N1".

Addendum DD1, Final ASC Payment Indicators for CY 2017, defines payment indicator "N1" as "Packaged service/item; no separate payment made."

The division finds that even though HCPCS code C1713 has a payment indicator of "N1", Section 413.011(b) of the Texas Labor Code, 28 Texas Administrative Code §134.402(d), and it's preamble, make the exception to Medicare's policies and allow separate reimbursement for implantables in non-device intensive procedures.

Based upon the submitted explanation of benefits, the respondent also denied reimbursement for the implantables based upon "225-Needing clarification of type and number of screws used during this procedure."

The division reviewed the requestor's documentation and finds no list of the implantables used in the procedure. The documentation included a DePuy Synthes invoices that list implantable and non-implantable charges, but not which ones were used in this procedure. The division finds the respondent's denial based upon reason code "225" is supported; therefore, additional reimbursement cannot 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	2/1/2018 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, 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 MFDR 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.