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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS SURGICAL CENTER

Respondent Name
TRI-STATE INSURANCE COMPANY OF MINNESOTA

MFDR Tracking Number
M4-18-1503-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 23, 2018

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: $628.25 is indicated on the DWC-60 and $55.44 on Position Statement .

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's DWC60 was somewhat misleading. It claims that the amount in dispute is $628.25. However, the provider's appeal dated December 12, 2017, which we are attaching claims that the provider is owed an additional $55.44. We would point out that the provider's DWC-60 indicates that the carrier had reimbursed the provider in the amount of $5,274.82. However, the provider's December 12, 2017 letter concedes that the carrier had already reimbursed the provider $5,956.87. In fact, we are attaching several EORs including one dated November 28, 2017 that shows payment of $5,956.87. The point is that there inconsistencies in the provider's own documents. The provider has already been reimbursed in accordance with the Medical Fee Guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2017	Ambulatory Surgical Care for CPT Code 29827	$0.00	$0.00
	Ambulatory Surgical Care for CPT Code 29826	$0.00	$0.00
	Ambulatory Surgical Care for HCPCS Code C1713	$55.44	$0.00
Total		$55.44	$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:
   - 96-Non-Covered Charges.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - W3-Additional payment made on appeal/reconsideration.

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the appropriate reimbursement for code 29827-RT?
3. Is the requestor due reimbursement for HCPCS 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 additional reimbursement of $628.25 for ambulatory surgical care services rendered on August 16, 2017.

   On the disputed date of service the requestor billed codes 29827-RT, 29826-RT and C1713. Per the DWC-60, the respondent paid $5,956.87 based upon the fee guideline. On the medical bill in box # 19, the rquestor seeks separate reimbursement for the implantables; therefore, the reimbursement methodology is found at 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii).

   28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) 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: (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."

   To determine the maximum allowable reimbursement (MAR) the Division gathered the following factors to be used in the calculations:

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

   The City Wage Index for Midland, Texas is 0.9123.

   The fully implemented ASC relative payment weight for code 29827 CY 2017 is $2,647.21.

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

The Medicare fully implemented ASC reimbursement rate is divided by 2 = $1,323.60

This number multiplied by the City Wage Index $1,207.52.

Add these two together = $2,531.12.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $3,872.61.

The respondent paid the requestor $5,956.87 based upon 28 Texas Administrative Code §134.402(f)(1)(A).

3. Per the DWC-60, the requestor is seeking reimbursement of $55.44 for HCPCS code C1713.

   The respondent contends that reimbursement is not due based upon reason code "96-Non-covered charge."

   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."

   According to *Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2015 (Including Ancillary Services for Which Payment is Packaged*), HCPCS Code C1713 has a payment indicator of "N1".

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

   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."

   28 Texas Administrative Code §134.402 (d)(1) states, "Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program."

   The exception to Medicare's policies for HCPCS code C1713 is found in 28 Texas Administrative Code §134.402(d)(1) and its' preamble.

   A review of the submitted documentation finds the following:

   - The requestor billed $1,940.00 for HCPCS code C1713.
   - Arthrex Invoices for $565.00, $5,700.00 and $1,500.00.
   - Implant record was not submitted to support which implants were used.

   Because the requestor did not support which implants were used in the procedure, the request for 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

		2/14/2018
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, 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.