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
GRAPEVINE SURGICARE

Respondent Name
OLD REPUBLIC INS CO

MFDR Tracking Number
M4-19-1150-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
OCTOBER 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2018 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $483.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per 28 TAC §134.404, reimbursement for implants is the manufacturer's invoice cost plus 10%. The total cost of the implants billed is $4,455.00. The total reimbursement for the implants, at manufacturer's invoice cost plus 10% is $4,900.50."

Response Submitted By: Foresight

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2018	Ambulatory Surgical Care for CPT Code 27758	$0.00	$0.00
	Ambulatory Surgical Care for CPT Code 27781	$0.00	$0.00
	Ambulatory Surgical Care for HCPCS Code C1713	$483.48	$65.50
Total		$483.48	$65.50

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 §133.305 sets out the general Medical Dispute Resolution guidelines.
1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Separate reimbursement requested for implants.
   - 00147-(109) Claim not covered by the payer/contractor. You must send the claim to the correct payer/contractor.
   - W3-Request for reconsideration.

Issues

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

2. Is the requestor due additional 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. The requestor billed and was paid $4,835.00 for HCPCS code C1713. The requestor is seeking additional reimbursement of $483.48 for HCPCS 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.”

   28 Texas Administrative Code §134.402(e) states, “Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables.

   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).”

   28 Texas Administrative Code §134.402(b)(5) states "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.”

   HCPCS code C1713 is defined as “Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable).”

   To determine if the requestor is due additional reimbursement the division refers to 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."

A review of the submitted documentation finds that the requestor submitted copies of invoices from OsteoMed that lists the cost of the implantables used in the surgery. A review of the Operative Report documents the insertion of Medial Distal Tibial Plate, 3.5mm screws and locking screws. The division finds the Operative Report does not document the Long Pilot Drill, Plate Holding Tak and Screw Driver were implanted, embedded, inserted, applied or necessary to operate, program, and recharge the implantable; therefore, reimbursement for these items is not recommended.

The Division reviewed the invoices and finds the cost for implantables is $4,455.00. The MAR for the implantables per 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) is $4,455.00 + cost plus 10% = $4,900.50. The respondent paid $4,835.00. The requestor is due the difference between the MAR and amount paid of $65.50.

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 $65.50.

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 $65.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/7/2019
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.