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**
LIBERTY INSURANCE CORP

**MFDR Tracking Number**
M4-19-4194-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
MAY 22, 2019

## *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:** $767.20

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The bill has been reviewed and payment was originally issued with implants included for $6111.91 paid at 235% at ASC rate…Payment was previously issued in the amount of $9801.53 has been issued to the provider."

**Response Submitted By:** Liberty Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 24, 2018 | Ambulatory Surgical Care Services (ASC)<br>CPT Code 29827 | $767.20 | $158.39 |
| | HCPCS Code C1713 | | |
| | HCPCS Code C1762 | | |

## *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, effective May 31, 2012, 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:
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - B839-In accordance with CMS guidelines, this service does not warrant a separate payment.
   - 170-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment. Previously paid.
   - W3-Additional payment made on appeal/reconsideration.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

**Issues**

Is the requestor due additional reimbursement for ASC services rendered on May 24, 2018?

**Findings**

1. On the disputed date of service, the requestor billed $ 16,600.00 for CPT codes 29827, C1713 and C1762. The respondent paid $9,801.53 for the ASC services. The requestor contends that the reimbursement was not in accordance with the ASC fee guideline and additional reimbursement of $767.20 is due for these codes.
2. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
3. To determine if the requestor is due additional reimbursement for ASC services, the division refers to the following statutes:

   - 28 Texas Administrative Code §134.402(b) (6) states:

     > Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   - 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.

   - 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.

- 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."

4. The codes in dispute are described as:
   - 29827 as "Arthroscopy, shoulder, surgical; with rotator cuff repair."
   - C1713 as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."
   - C1762 as "Connective tissue, human (includes fascia lata)."
5. Per ADDENDUM AA, CPT code 29827 is a non-device intensive procedure.

   Per 28 Texas Administrative Code §134.402(f)(1)(B)(ii),the following formula was used to calculate the MAR:
   The Medicare fully implemented ASC reimbursement for code 29827 CY 2018 is $2,721.37.
   This number is divided by 2 = $1,360.68.
   This number multiplied by the City Wage Index for Midland, Texas is $1,360.68 X 0.9114 = $1,240.12.
   The geographically adjusted rate is found by adding these two numbers together = $2,600.80.
   To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $3,979.22. The respondent paid $2,129.53 ($6,111.91 original payment less $3,982.38 taken upon reconsideration).

6. The division reviewed the submitted Operative Report and invoice from Arthrex and finds:

| CODE | Product Description | Qty. | Cost | Cost + 10% | Amount Paid |
|---|---|---|---|---|---|
| C1713 | Arthro Flex 4 x 7 cm with 3mm thickness | 1 | Invoice or Cost information not submitted | $0.00 | $7,672.00 |
| C1713 | 4.75 SwiveLocks X 19. 1 | 2 | Invoice or Cost information not submitted | $0.00 | |
| C1713 | 4.75 SwiveLocks X 24 | 2 | $420.00 X 2 = $840.00 | $924.00 | |
| C1713 | BioComposite corkscrew 4.5 x 14 | 2 | $325.00 X 2 = $650.00 | $715.00 | |
| C1713 | 3mm Suture Tak | 1 | Invoice or Cost information not submitted | $0.00 | |

| | | | | | |
|---|---|---|---|---|---|
| C1762 | B-cellular dermal graft | 1 | $3,947.00 | $4,341.70 | |

7. The total due for ASC services rendered on May 24, 2018 is $9,959.92. The total amount paid is $9,801.53. As a result, additional reimbursement 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 $158.39.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $158.39, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | | |
|---|---|---|
| | | 7/3/2019 |
| 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**.