



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

NORTH GARLAND SURGERY CENTER

Respondent Name

ZENITH INSURANCE CO

MFDR Tracking Number

M4-19-4334-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

JUNE 3, 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: \$621.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The original payment was processed at a higher rate in error not taking into account that the provider was seeking separate reimbursement for implants. The additional payment processed on 03/12/2019, has resulted in an overpayment of \$442.79. No additional payment is due to the provider."

Response Submitted By: The Zenith

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include Ambulatory Surgical Care Services (ASC) CPT Code 28485, HCPCS Code C1713, HCPCS Code L8699, and a TOTAL row.

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:
  - P12-Workers' compensation jurisdictional fee schedule adjustment.
  - 618-TX the value of this procedure is packaged into the payment of other services performed on the same date of service.
  - 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 his claim was processed properly.
  - 18-Exact duplicate claim/service.

## **Issues**

Is the requestor due additional reimbursement for ASC services rendered on November 8, 2018?

## **Findings**

1. On the disputed date of service, the requestor billed \$ 10,818.07 for CPT codes 28485, C1713 and L8699. The respondent paid \$6,924.13 for the ASC services. The requestor contends that the reimbursement was not in accordance with the ASC fee guideline and additional reimbursement of \$621.30 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:

- 28485 as "Open treatment of metatarsal fracture, includes internal fixation, when performed, each."
- C1713 as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."
- L8699 as "Prosthetic implant, not otherwise specified."

5. Per ADDENDUM AA, CPT code 28485 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 28485 CY 2018 is \$2,721.37.

This number is divided by 2 = \$1,360.68.

This number multiplied by the City Wage Index for Garland, Texas is \$1,360.68 X 0.9848 = \$1,339.99.

The geographically adjusted rate is found by adding these two numbers together = \$2,700.67.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = \$4,132.02. The respondent paid \$6,346.62. difference between MAR and payment results in overpayment of \$2,214.60.

6. The division reviewed the submitted Implant Record and invoice from Paragon and finds:

CODE	Product Description	Qty.	Cost	Cost + 10%	Amount Paid	Amount Due
C1713	8 hole T-Plate	1	\$971.75	\$1,068.92	\$577.51	\$2,792.07
C1713	2.5 X 14mm locking screw	1	\$201.50	\$221.65		
C1713	2.5 X 12mm non-locking screw	1	\$156.00	\$171.60		
C1713	2.5 X 12mm locking screw	3	\$201.50 X 3 = \$604.50	\$664.95		
C1713	2.5 X 11mm locking screw	2	\$201.50 X 2 = \$403.00	\$443.30		
C1713	2.5 X 8mm locking screw	1	\$201.50	\$221.65		
L8699	Not given	0	\$0.00	\$0.00	\$0.00	\$0.00

7. The total due for ASC services rendered on November 8, 2018 is \$6,924.09. The total amount paid is \$6,924.13. As a result, additional reimbursement is not 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

\_\_\_\_\_  
Date

7/3/2019

***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.**