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**
BAYLOR SURGICARE AT PLANO

**Respondent Name**
HARTFORD UNDERWRITERS INSURANCE CO

**MFDR Tracking Number**
M4-19-4335-01

**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 2019 Texas Workers Compensation Fee Schedule and Guidelines."

**Amount in Dispute:** $3,634.35

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Based on the provider invoice (page 14), the Amnion Thin, item number ABS-4100-048 is Human Amniotic Tissue and considered experimental/investigational. Additionally, item number AR-1322DSC, Kit Anchor Suture Bit Drill listed cost of $250 is considered a Disposable Item not an actual implant. Therefore, in conclusion, all implantable medical device qualified items per regulations definition have been reimbursed at provider's submitted cost plus 10%."

**Response Submitted By:** Foresight Implant Cost Containment

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 21, 2018 | Ambulatory Surgical Care Services (ASC) CPT Code 27698 | $0.00 | $0.00 |
| | ASC CPT Code 28120 | $0.00 | $0.00 |
| | HCPCS Code C1713 | $1,228.46 | $654.70 |
| | HCPCS Code L8699 | $2,405.90 | $2,405.90 |
| TOTAL | | $3,634.35 | $3,060.60 |

## *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.
   - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 4458-Foresight-Charges for surgical implants are reviewed separately by Foresight Medical.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
   - 18-Exact duplicate claim/service.
   - 131-Claim specific negotiated discount.
   - 247-A payment or denial has already been recommended for this service.
   - 197-Recommended allowance based on negotiated discount/rate.

**Issues**

Is the requestor due additional reimbursement for HCPCS codes C1713 and L8699 rendered on September 21, 2018?

**Findings**

1. On the disputed date of service, the requestor billed $2,988.00 and was paid $2,057.90 for HCPCS code C1713, and billed $3,725.00 and was paid $1,691.60 for HCPCS code L8699. The requestor contends that the reimbursement was not in accordance with the ASC fee guideline and additional reimbursement of $3,634.35 is due for these codes.
2. 28 Texas Administrative Code §133.307(d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   The Division finds that the respondent raises issues in the position summary that were not presented to the requestor prior to the date the request for MFDR was filed with the division. A review of the submitted explanation of benefits does not list any denial reasons to support HCPCS code L8699, the Amnion Thin, was denied based upon "experimental/investigational"; therefore, the response was not submitted in accordance with 28 Texas Administrative Code §133.307.
3. According to the submitted explanation of benefits, the respondent reduced payment for HCPCS code C1713 and L8699 based upon a "claim specific negotiated discount". A review of the submitted documentation finds no contractual agreement between Hartford Underwriters Insurance Co. and Baylor Surgicare at Plano to support this claim adjustment reason code; therefore, the disputed services will be reviewed per the division's fee guideline.
4. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.

5. 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."

6. The HCPCS codes in dispute are described as:

   - C1713 as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."
   - L8699 as "Prosthetic implant, not otherwise specified."

7. The division reviewed the submitted Implant Record and invoice from Arthrex and finds:

| CODE | Product Code Number per Implant Record | Product Description | Cost | Cost + 10% | Amount Paid | Amount Due |
|---|---|---|---|---|---|---|
| C1713 (X2) | AR-1322BCNF | Suture Anchor | $465.00 X 2 = $930.00 | $1,023.00 | $2,057.90 | $2,712.60 -$2,057.90= $654.70 |
| C1713 | AR1688-CP | Implant System, | $1,536.00 | $1,689.60 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Internal Brace | | | | |
| L8699 | ABS-4100-048 | Amnion Thin | $3,725.00 | $4,097.50 | $1,691.60 | $2,405.90 |

**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 $3,060.60.

***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 $3,060.60, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 7/3/2019<br>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**.