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
METROCREST SURGERY CENTER

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-4707-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 28, 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: $1,685.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has already been reimbursed $9,260.64. The reimbursement amount is in accordance with the Medical Fee Guidelines. The provider is not entitled to any additional reimbursement."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 29806	$0.00	$0.00
	ASC CPT Code C1762	$497.81	$0.00
	HCPCS Code C1713	$1,188.00	$0.00
TOTAL		$1,685.81	$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, 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:
   - 45-Charge exceeds fee schedule/maximum allowable or contracted /legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount and must not duplicate provider adjustment amounts payments and contractual.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor due additional reimbursement for HCPCS codes C1713 and C1762 rendered on March 5, 2019?

Findings

1. On the disputed date of service, the requestor billed $3,694.55 and was paid $3,566.20 for HCPCS code C1762, and billed $2,466.00 and was paid $1,524.60 for HCPCS code C1713. The requestor contends that the reimbursement was not in accordance with the ASC fee guideline and additional reimbursement of $1,685.81 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 HCPCS codes in dispute are described as:
   - C1762 as "Connective tissue, human (includes fascia lata)."
   - C1713 as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."
5. The division reviewed the submitted Operative report and invoices from Life Net Health Packing Slip and Arthrex and finds:

CODE	Product Description	Cost	Cost + 10%	Amount Paid
C1762	Decellularized Dermis	Not Listed	Not Listed	$3,566.20
C1713	3.0 Bio-Suture TAK	$391.00	$430.10	$1,524.60
C1713	4.75 Corkscrew	$408.00	$448.80	
C1713	3.9 PEEK corkscrew	$442.00	$486.20	
C1713	4.75 SwiveLock (X2)	$540.00 X 2 = $1,080.00	$1,188.00	
C1713	4.75 Swivelock (X2)	$489.00 X 2 = $978.00	$1,075.80	
TOTAL		$3,299.00	$3,628.90	$5,090.80

Based upon the above findings, the division finds the requestor is not due additional reimbursement for HCPCS codes C1762 and C1713.

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

		7/25/2019
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.