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 MANSFIELD

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-19-4794-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 8, 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: $4,388.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is billing for multiple items, of which, item billed under C1713 does not meet the definition of an implant per regulations. The allowance under C1713 (232.44) was applied to the total calculated reimbursement amount due for C9359 ($220.00). Therefore, the reconsideration did not allow additional because an overpayment was determined to have occurred."

Response Submitted By: AIG/Foresight

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 28100	$0.00	$0.00
	ASC CPT Code 20680	$0.00	$0.00
	ASC CPT Code C9359	$138.74	$0.00
	HCPCS Code C1713	$4,250.06	$3,936.26
TOTAL		$4,388.80	$3,936.26

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:
    - Workers' compensation Medical Treatment Guideline Adjustment.
    - Charge for surgical implants are reviewed separately by ForeSight Medical.
    - No additional reimbursement allowed after review of appeal/reconsideration.
    - 10-Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.
    - 2-Device payment was based on documentation provided by your facility.

Issues

Is the requestor due additional reimbursement for ASC services rendered on December 17, 2018?

Findings

1. The requestor is seeking additional reimbursement of $4,388.80 for ASC services rendered on December 17, 2018.
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:
   - C9359 as "Porous purified collagen matrix bone void filler (integra mozaik osteoconductive scaffold putty, integra os osteoconductive scaffold putty), per 0.5 cc."
   - C1713 as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."
5. The division reviewed the submitted documentation and finds:

Code	Cost	MAR	Carrier Paid	Amount Due
C9359	No cost invoices were submitted to support cost; therefore, reimbursement not recommended.			
C1713	$4,075.00	$4,482.50	$232.44	$4,250.06

6. The requestor also listed on the Table of Disputed Services, CPT codes 28100 and 20680.

   Per ADDENDUM AA, CPT codes 28100 and 20680 are non-device intensive procedure.

   28 Texas Administrative Code §134.402(f)(1)(B) 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: A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

   The following formula was used to calculate the MAR:

   - The Medicare fully implemented ASC reimbursement for code 28100 CY 2018 is $1,279.91.

     This number is divided by 2 = $639.95.

     This number multiplied by the City Wage Index for Mansfield, Texas 0.9590 = $613.71.

     Add these two together = $1,253.66.

     To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,946.10.

   - The Medicare fully implemented ASC reimbursement for code 20680 CY 2018 is $1,062.77.

This number is divided by 2 = $531.38.

This number multiplied by the City Wage Index for Mansfield, Texas 0.9590 = $509.59.

Add these two together = $1,040.97.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,446.27.

7. The division finds the total allowable for ASC services rendered on December 17, 2018 is $9,642.43. The insurance carrier paid $5,706.17. The requestor is due the difference between MAR and amount paid of $3,936.26

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 $3,936.26.

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 $3,936.26, 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	Date
		9/16/2019

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.