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
NORTH GARLAND SURGERY CENTER

Respondent Name
TEXAS MUNICIPAL LEAGUE INTERGOVERNMENTAL RISK

MFDR Tracking Number
M4-19-5150-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 9, 2019

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: $661.20

RESPONDENT'S POSITION SUMMARY

"The Provider has been reimbursed based upon the medical bill documentation that the carrier has received from the provider in conjunction with the Medical Fee Guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 6, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 29827	$0.00	$0.00
	ASC CPT Code 29824	$0.00	$0.00
	ASC CPT Code 29826	$0.00	$0.00
	HCPCS Code C1713	$888.12	$0.00
	HCPCS Code L8699	$386.60	$0.00
TOTAL		$661.20	$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 (DWC).

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:
   - 16, 405-Submit supply house invoice for each implant provider requested 153% + implant cost + 10%.
   - W3, 351-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

Is the requestor due additional reimbursement for HCPCS codes C1713 and L8699 rendered on September 6, 2018?

Findings

1. On the disputed date of service, the requestor billed $2,329.20 and was paid $1,674.00 for HCPCS code C1713, and billed $616.00 and was paid $291.00 for HCPCS code L8699. The requestor contends that the reimbursement was not in accordance with the ASC fee guideline and additional reimbursement of $661.20 is due for these codes.
2. The fee guideline for ASC services is found in 28 TAC §134.402.
3. To determine if the requestor is due additional reimbursement for ASC services, the DWC refers to the following statutes:
   - 28 TAC §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 TAC §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 TAC §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 TAC §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:
   - C1713 as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."
   - L8699 as "Prosthetic implant, not otherwise specified."
5. A review of the submitted documentation finds the requestor submitted copies of implant invoices from CPM Medical Consultants, LLC for $450.00; Arthrex for $1,245.00; Zimmer Biomet for $870.37; and Valeris Medical Inc for $1,072.50. The requestor did not submit an implant record or a list to identify which implantables on these invoices corresponded to HCPCS codes C1713 and L8699; therefore, additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the DWC 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 services in dispute.

Authorized Signature

		9/11/2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.