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 PARKWAY

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-20-1728-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
MARCH 16, 2020

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: $2,468.40

RESPONDENT'S POSITION SUMMARY

"The Provider contends they are entitled to reimbursement for CPT code C1713 (anchors/screws). The Carrier has reviewed the documentation and determined the Provider was properly reimbursed. The operative report, included in the Request for Medical Fee Dispute Resolution, does not document any anchors or screws utilized in the surgery. As the implantables represented by C1713 were not used in the surgery, n reimbursement is due for those implantables. Furthermore, the invoice documents that the charges were for a Ligament Repair Kit. There is no documentation in the operative report that a repair kit was used or that a repair kit component was implanted as part of the surgery. As the documentation does not support the coded service, reimbursement is not due."

Response Submitted By: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 25447	$0.00	$0.00
	ASC Services HCPCS Codes C1713	$2,468.40	$1,444.92
TOTAL		$2,468.40	$1,444.92

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 (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 TAC §133.10, sets out the required health care provider billing procedures.
4. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - 251-The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.
   - 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.
   - 8768-Review of the submitted documentation does not substantiate or warrant separate payment. The Implant kit billed contains supplies that are not separately reimbursable. For payment consideration re-submit with itemized invoice for cost of implanted item(s) only.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

Is the requestor due reimbursement for HCPCS code C1713 rendered on August 8 2019?

Findings

On the disputed date of service the requestor billed for ASC services related to HCPCS codes 25447-FA and C1713. The respondent paid $2,933.08 for code 25447 based upon the fee guideline. The requestor is seeking medical fee dispute resolution in the amount of $2,468.40 for HCPCS code C1713.

The fee guideline for ASC services is found at 28 TAC §134.402.

A. CPT Code 25447:

Per Addendum AA code 25447 is a non-device intensive procedure.

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 percent.per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 25447 CY 2019 is $1,256.79.

The Medicare ASC reimbursement is divided by 2 = $628.39.

This number multiplied by the City Wage Index for Plano, Texas of 0.9862= $619.72.

Add these two together = $1,248.11.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $1,909.60.

B. HCPCS Code C1713:

HCPCS code C1713 is defined as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

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."

The DWC reviewed the submitted documentation and finds:

- Arthrex invoice lists Collagen Coated Fibertape and H/W Internal Brace Ligament Augment Repair Kit for $2,244.00.
- The Operative report indicates guidewire, internal brace, and Fibertape were used in the procedure. The DWC finds the requestor supported position that reimbursement is due.
- The DWC finds the MAR for HCPCS code C1713 is $2470.82; however, the requestor is seeking a lesser amount of $2,468.40. The respondent paid $0.00. The requestor is due the difference of $2,468.40.

The DWC finds the total due for ASC services related to code 25447 and C1713 is $4,378.00. The respondent paid $2,933.08. The requestor is due the difference of $1,444.92.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,444.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $1,444.92 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	04/08/2020 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.