TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICARE AT MANSFIELD

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-20-2341-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MAY 18, 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: $864.75

RESPONDENT'S POSITION SUMMARY

"The provider's Arthrex Sales Order indicates that the items charged are invoiced at $572.00 each. This document is not a true invoice, but is a pricing sheet…Foresight recommended an allowance for Revenue Code 0278, Service Code C1713 at $1,672.00, which is the cost of the screws at $1,520.00 plus 10%."

Response Submitted By: Foresight

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 29827	$0.00	$615.98
	ASC Services for CPT Code 29824	$0.00	
	ASC Services for CPT Code 29826	$0.00	
	ASC Services for HCPCS Codes C1713	$1,064.80	
TOTAL		$864.75	

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:
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 102-Multiple surgery rules allow for this procedure to be paid at 50%.
   - 148-This procedure on this date was previously reviewed.
   - 861-This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
   - 896-Claim processed in accordance with ambulatory surgical guideline.
   - 131-Claim specific negotiated discount.
   - 18-Duplicate claim/service.
   - 59-Processed based on multiple or concurrent procedure rules.
   - CIQ377-Additional recommendation is based upon additional supporting documentation received.
   - Charges for surgical implants will be reviewed separately by ForeSight Medical.

Issues

Is the requestor due additional reimbursement for ASC services rendered on May 22, 2019?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $864.75 for ASC services rendered on May 22, 2019.

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

The requestor sought separate reimbursement for the implantables; therefore, 28 TAC §134.402(f)(1)(B)(i)(ii) applies to this dispute.

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.

A. CPT Code 29827:

Per Addendum AA code 29827 is a non-device intensive procedure.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 29827 CY 2019 is $2,744.32.

The Medicare ASC reimbursement is divided by 2 = $1,372.16.

This number multiplied by the City Wage Index for Mansfield, Texas of 0.9703= $1,331.41.

Add these two together = $2,703.57.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $4,136.46.

B. CPT Code 29824

Per Addendum AA code 29824 is a non-device intensive procedure.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 29824 CY 2019 is $1,256.79.

The Medicare ASC reimbursement is divided by 2 = $628.40.

This number multiplied by the City Wage Index for Mansfield, Texas of 0.9703= $609.73.

Add these two together = $1,238.13.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $1,894.34. CPT Code 29824 is subject to multiple procedure discounting of 50% = $947.17.

C. CPT Code 29826

Per Addendum AA code 29826 is classified as “N1-Packaged service/item; no separate payment made.”

Therefore, no reimbursement is recommended.

D. 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 respondent wrote, “The provider’s Arthrex Sales Order indicates that the items charged are invoiced at $572.00 each. This document is not a true invoice, but is a pricing sheet…Foresight recommended an allowance for Revenue Code 0278, Service Code C1713 at $1,672.00, which is the cost of the screws at $1,520.00 plus 10%.”

The DWC reviewed the submitted documentation and finds:

- The respondent did not submit any documentation to support position that the cost of the screws was $1,520.00.

- The Ortho/Plastic Chargeables and Implants report lists the implantable as "AR-2324BCC (X2)," and "AR-2324BCCTT (X2).
- Arthrex invoice list the cost of AR-2324BCC at $572.00/each and $672.00 for AR-2324BCCTT (X2).
- The DWC finds per 28 TAC §134.402(f)(1)(B)(i)(ii) the MAR is $2,736.80 for the implantables; however, the requestor is seeking $2,488.00.

The DWC finds the total due for ASC services rendered on May 22, 2019 is $7,571.63. The respondent paid $6,955.65. As a result, additional reimbursement of $615.98 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $615.98.

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 $615.98 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	06/16/2020 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.