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 PARK

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2524-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 17, 2020

REQUESTOR'S POSITION SUMMARY

"At this time we are requesting that this claim paid in accordance with the 2020 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $4,004.00

RESPONDENT'S POSITION SUMMARY

"BAYLOR SURGICARE AT PLANO PARK submitted their initial bill and requested 153% plus implant cost plus 10%. At the time of the audit, the provider did not include the implant certification per Rule 134.402(g)(B). An Appeal was received, the provider did not submit implant cost certification for the date of service; however the date signed and certified, is not consistent with the disputed date of service…The provider submitted an implant certification with the DWC60 packet, the same one submitted on the appeal... No additional payment."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 27698	$0.00	$0.00
	ASC Services for CPT Code 27626	$0.00	$0.00
	ASC Services for CPT Code 29898	$0.00	$0.00
	ASC Services for HCPCS Codes C1713	$4,004.00	$0.00
TOTAL		$4,004.00	$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 (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:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16-Claim/service lacks information or has submission billing error(s) which is needed for adjudication.
   - D25-Approved non network provider for Workwell.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 790-This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
   - 764-Reimbursed per ASC FG at 153%. Separate reimbursement for implantables (including signed certification) was requested per rule 134,402(G).

Issues

Is the requestor due reimbursement for HCPCS code C1713 rendered on March 2, 2020?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $4,004.00 for HCPCS code C1713 rendered on March 2, 2020.

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.

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 denied reimbursement based upon “892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions,” “CAC-16-Claim/service lacks information or has submission billing error(s) which is needed for adjudication,” and “225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.”

The respondent wrote “At the time of the audit, the provider did not include the implant certification per Rule 134.402(g)(B). An Appeal was received, the provider did not submit implant cost certification for the date of service; however the date signed and certified, is not consistent with the disputed date of service.”

28 TAC §134.402(g)(1)(B) states,

> A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable. (1) The facility or surgical implant provider requesting reimbursement for the implantable shall: (B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled.

The DWC reviewed the submitted documentation and finds the implant cost certification was dated May 7, 2020. The DWC finds the requestor did not support that the implant cost certification was included with the billing as required by 28 TAC §134.402(g)(1)(B); therefore, the respondent’s denial of payment is supported.

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 disputed services.

Authorized Signature

		07/10/2020
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.