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
CORPUS CHRISTI OUTPATIENT SURGERY CENTER

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-20-2614-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JUNE 30, 2020

REQUESTOR'S POSITION SUMMARY

"All billed procedure codes are to be reimbursed at: Procedure Code 28415: $3,667.36…Procedure Code C1713: $2,285 (implant cost) + 10% = $2,513.50. Total expected reimbursement: $6,180.86."

Email dated August 27, 2020: "Yes ma'am, you're welcome and Liberty Mutual made 2 separate payments, one for $1.33 and another for $60.80 adding up to a total of $62.13.

Amount in Dispute: $643.80

RESPONDENT'S POSITION SUMMARY

"Upon review of the dispute, we have determined that additional payment is warranted, but not what the providers is requesting. Provider is due: 28415 for $3667.36. C1713-billing for items that are not implants. Per operative report used: Arthrex AR-8954YL-S Plate for $1095.00; Arthrex locking screw x4 at $150.00 each = $600.00; Arthrex cortical screw for $60.00; Total $1755.00 plus 10% = $1930.50. 3667.36 plus 1930.50=$5597.86. Previous payment $5537.06. Additional owed would be $60.80."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 28415	$0.00	$0.00
	ASC Services for CPT Code 27675	$0.00	$0.00
	ASC Services for CPT Code 64445	$0.00	$0.00
	ASC Services for HCPCS Codes C1713	$643.80	$0.00

TOTAL		$643.80	$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:
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
   - 899-In accordance with Clinical Based Coding Edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery; musculoskeletal system procedure (20000-29999) has been disallowed.
   - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 4915-The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor due additional reimbursement for ASC services rendered on September 12, 2019?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $643.80 for ASC services rendered on September 12, 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)(2)(B)(i)(ii) applies to this dispute.

28 TAC §134.402(f)(2)(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:

(2) Reimbursement for device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the 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 ASC service portion multiplied by 235 percent.

The following formula was used to calculate the MAR:

- Step 1 calculating the device portion of the procedure:

  The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 28415 for CY 2019 = $5,699.59

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 28415 for CY 2019 is 36.49%

  Multiply these two = $2,079.78

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 28415 for CY 2019 is $3,757.39.
  This number is divided by 2 = $1,878.70.
  This number multiplied by the City Wage Index for Corpus Christi, Texas of 0.9377 = $1,761.65.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,640.35.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,560.57.

  Multiply the service portion by the DWC payment adjustment of 235% = $3,667.34.

The DWC finds the MAR for CPT code 28415 is $3,667.34. The respondent paid $3,667.36. The requestor is not seeking dispute resolution for this code.

A. 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 a lack of documentation to support billed services.

The DWC reviewed the submitted documentation and finds:

- The Arthrex invoice lists a total of $2,285.00.
- The Operative report indicates, “Provisional fixation was placed and an Arthrex sinus tarsi lateral plate was applied. Two distal locking screws and two proximal locking screws were applies…Schanz pin…a cortical screw was placed into the most proximal inferior aspect of the plate.” The number of implantables on the invoice do not correspond to the number listed in the Operative report.
- The requestor did not submit the implant record report to support what implantables were used in procedure.

- The respondent's denial of payment is supported because the documentation does not support amount sought.

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

		09/08/2020
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.