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
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-20-2975-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
AUGUST 21, 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: $16,940.87

RESPONDENT'S POSITION SUMMARY

"Additional recommended allowance of $17,321.53 on Case ID…completed processing in our system today and should be available in Risxfacs within 48-72 hours."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 28730	$0.00	$0.00
	ASC Services for CPT Code 64708	$18.62	
	ASC Services for HCPCS Codes C1713	$19,339.36	
TOTAL		$16,940.87	$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:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 59-Processed based on multiple or concurrent procedure rules.
   - 234-This procedure is not paid separately.
   - 223-Adjustment code for mandated federal, state, or local law regulation that is not already covered by another code and is mandated before a new code can be created.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 5283-Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or car.

Issues

Is the requestor due additional reimbursement for ASC services rendered on May 1, 2020?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $16,940.87 for ASC services rendered on May 1, 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)(2)(B)(i)(ii) applies to this dispute.

A. CPT Code 28730:

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.

Per Addendum AA code 28730 is a device intensive procedure.

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 28730 for CY 2020 = $11,900.71.

The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 27792 for CY 2020 is 50.99%

Multiply these two = $6,068.17.

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 28730 for CY 2020 is $8,734.86.
  This number is divided by 2 = $4,367.43.
  This number multiplied by the City Wage Index for Mansfield, Texas of 0.9792 = $4,276.59.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$8,644.02.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $2,575.85.

  Multiply the service portion by the DWC payment adjustment of 235% = $6,053.24.

- Step 3 calculate the MAR by adding the device and service portions = $12,121.41

The DWC finds the MAR for CPT code 28730 is $12,121.41.

A. CPT Code 64708

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.

Per Addendum AA code 64708 is a non-device intensive procedure.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 64708 CY 2020 is $796.79.

The Medicare ASC reimbursement is divided by 2 = $398.40.

This number multiplied by the City Wage Index for Mansfield, Texas of 0.9792= $390.10.

Add these two together = $788.50.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $1,206.42. CPT Code 64708 is subject to multiple procedure discounting of 50% = $603.21.

C. HCPCS Code C1713

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.

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:

- The Ortho/Plastic Chargeables and Implants report lists the implantable as:

Description or Number	No. Of Units	Cost	MAR
8mm Wedge 194233-020	1	$2,933.00	$3,226.30
10mm Wedge 173881.021	1	$2,933.00	$3,226.30
BioMet Concentration System 800-0611-A	1	$1,201.00	$1,321.10
BioMet DBM Putty	1	$773.00	$850.30
Agilon 003-AGL	1	$1,850.00	$2,035.00
Total			$10,659.00

- The CPM Medical Consultants, LLC invoice list other items not reported on the Ortho/Plastic Chargeables and Implants report. A review of the Operative Report does not support these items; therefore, reimbursement is not recommended.

The DWC finds the total due for ASC services rendered on May 1, 2020 is $23,383.62. The respondent originally paid $9,313.17. Upon receipt of the dispute, the respondent reconsidered the payment and wrote an additional reimbursement of $17,321.53 was recommended for a total of $26,634.70. As a result, additional reimbursement is not 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 disputed services.

Authorized Signature

		09/28/2020
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.