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
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-0302-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 19, 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."

Requestor's Supplemental Position: "We did get an additional payment on 11/05/20 but the claim is still underpaid according to the fee schedule. I would like the continue with dispute resolution unless the carrier has made another payment that we have not gotten at this time."

Amount in Dispute: $4,246.36

RESPONDENT'S POSITION SUMMARY

"The bill has been reviewed and adjusted for payment for CPT C1713-copies of EOBs are submitted for your review."

Attachment: EOBs support payment of $5,610.00 for CPT code C1713 less overpayment of $1,965.07 resulting in check issued of $3,644.93 on October 30, 2020.

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 27792	$0.00	$0.00
	ASC Services for HCPCS Codes C1713	$6,187.50	$23.89
TOTAL		$4,246.36	$23.89

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. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - 162-Code description not listed.
   - 4915-The charge for the services presented by the revenue code are included/bundled into the total facility.
   - 11-The recommended allowance for the supply was based on the attached invoice.
   - 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.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor due additional reimbursement for ASC services rendered on August 10, 2020?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $4,246.36 for ASC services rendered on August 10, 2020.

The respondent paid $9,588.67 ($5,943.74 + $3,644.93) for the disputed services based upon the fee guideline.

The requestor contends that additional reimbursement is due per the fee guideline.

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.

A. CPT Code 27792:

Per Addendum AA code 27792 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 27792 for CY 2020 = $5,981.95

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 27792 for CY 2020 is 32.68%

  Multiply these two = $1,954.90

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 27792 for CY 2020 is $3,704.99.
  This number is divided by 2 = $1,852.50.
  This number multiplied by the City Wage Index for Plano, Texas of 0.9747 = $1,805.63.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,658.13.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,703.23.

  Multiply the service portion by the DWC payment adjustment of 235% = $4,002.56.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the service portion and implantables.

B. HCPCS Code C1713

The DWC reviewed the implant record and invoices and finds the following:

Implant	No of Units	Cost	Cost + 10%
Cortical Screw	4	$295.00	$324.50 X 4 =$1,298.00
Plate 5-Hole	1	$2,795.00	$3,074.50
Locking Screw	3	$375.00	$412.50 X 3 =$1,237.50
Tight Rope	Not included in appeal or DWC-60; therefore, cost not considered		
TOTAL			$5,610.00

The DWC finds the total due for ASC services rendered on August 10, 2020 is $9,612.56. The respondent paid $9,588.67. As a result, additional reimbursement of $23.89 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 $23.89.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $23.89, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

		12/14/2020
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.