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 BLUE STAR

Respondent Name
STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number
M4-21-0365-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 26, 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 for Ambulatory Surgical Centers."

Amount in Dispute: $6,734.65

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 24341	$3,098.11	$3,098.10
	HCPCS Code C1713	$3,636.54	$1,548.74
TOTAL		$6,734.65	$4,646.84

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 §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 codes:
   - 00950-This bill is a reconsideration of a previously reviewed bill. Allowance amounts reflect any changes the previous payment.
   - 237-The recommended allowance is based on usual, customary and reasonable rates for this geographical area.
   - 5283-Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines usual and customary policies, provider's contract.
   - 76-Billing is greater than surgical fee.
   - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
   - 93-No claim level adjustments.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on July 28, 2020?

Findings

1. The Austin carrier representative for Starr Indemnity & Liability Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson received a copy of this medical fee dispute on November 3, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution in the amount of $6,734.65 for ASC services rendered on July 28, 2020.
3. The respondent paid $1,675.84 for the ASC services based upon the fee guideline.
4. The fee guidelines for disputed services is found in 28 TAC §134.402.
5. To determine the appropriate reimbursement for CPT code 24341and C1713, the DWC refers to 28 TAC §134.402(f).

   A. Per ADDENDUM AA, CPT codes 24341 is a non-device intensive procedure.

   28 TAC §134.402(f)(1)(B) states,

   (f) 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 percent.

   The following formula was used to calculate the MAR:

   The Medicare ASC reimbursement for code 24341 CY 2020 is $2,803.36.

   The Medicare ASC reimbursement is divided by 2 = $1,401.68.

This number multiplied by the City Wage Index for Frisco, Texas of 0.9747= $1,366.22.

Add these two together = $2,767.90.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $4,234.88. The respondent paid $1,136.78. The requestor is due the difference of $3,098.10.

B. 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 DWC reviewed the submitted documentation and finds:

- The Operative report indicates "the buttons were then inserted."
- The requestor did not submit an implant record to support any other implants used in the procedure.
- Arthrex invoice lists the cost for "Large Pec Button Kit" at $1,898.00. Per 28 TAC §134.402(f)(1)(B), the MAR is $2,087.80. The respondent paid $539.06. The requestor is due the difference between the MAR and paid of $1,548.74.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $4,646.84.

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 $4,646.84, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

		01/06/2021
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 Rule §133.307, effective May 31, 2012, *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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.