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 OF PLANO

Respondent Name
VALLEY FORGE INSURANCE CO

MFDR Tracking Number
M4-21-0611-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
DECEMBER 2, 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."

Requestor's Supplemental Position Summary: "The additional payment we received from the carrier was only $195.54. Not the $1558.68 in dispute so I say continue with dispute resolution."

Amount in Dispute: $1,558.68

RESPONDENT'S POSITION SUMMARY

"Upon receipt of the documentation for this MDR Medical Fee Dispute, Carrier sent the documentation for review by Conduent. After review, Conduent advised that additional allowable is due."

Respondent's Supplemental Position Summary: "Payment in the amount of $195.54 was issued to and cashed by Requestor."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 20690	$470.68	$470.68
	ASC Services for CPT Code 20680	$480.12	<$324.92>
	ASC Services for HCPCS Code C9290	$195.55	$0.00
	ASC Services for HCPCS Code C1713	$412.13	$412.13
TOTAL		$1,558.68	$557.89

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 §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:
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P5-Based on payer reasonable and customary fees, no maximum allowable defined by legislated fee arrangement.
   - 942-Separate reimbursement for this line item is denied. The clinical information and detail submitted on the procedures rendered, indicates that separate reimbursement for this line would be inappropriate or has been included in the vale of the procedure performed.
   - 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.
   - 954-The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - P16-Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.
   - 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 1014-The attached billing has been re-evaluated at the request of the provider based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
   - 4915-The charge for the services presented 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.
   - 4281-Overpayment recoupment.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on July 8, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,558.68 for ASC services rendered on July 8, 2020.
2. Upon receipt of this request for medical fee dispute resolution, the respondent issued an additional reimbursement of $195.54 for a total reimbursement of $10,066.83. The respondent contends that reimbursement was per the fee guideline.
3. The fee guidelines for disputed services is found in 28 TAC §134.402.

   28 TAC §134.402(d) states,

For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

The disputed services are described as:

- "20680- Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)."
- "20690- Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system."
- "C9290- Injection, bupivacaine liposome, 1 mg."
- "C1713- Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

4. The requestor is seeking separate reimbursement for the implantables. To determine the appropriate reimbursement the DWC refers to 28 TAC §134.402(f).

   A. Per ADDENDUM AA, CPT codes 20690 is a device intensive procedure.

   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 20690 for CY 2020 = $5,981.95.

     The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 20690 for CY 2020 is 30.75%

     Multiply these two = $1,839.45

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare ASC reimbursement rate for code 20690 for CY 2020 is $3,756.31.
     This number is divided by 2 = $1,878.16.
     This number multiplied by the City Wage Index for Plano, Texas of 0.9747 = $1,830.64.
     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,708.80.
     The service portion is found by taking the geographically adjusted rate minus the device portion = $1,869.35.

     Multiply the service portion by the DWC payment adjustment of 235% = $4,392.97.

   The DWC finds the MAR for CPT code 20690 is $4,392.97. The respondent paid $3,922.27. The requestor is due the difference of $470.70 or less. The requestor is seeking $470.68.

   B. Per ADDENDUM AA, CPT code 20680 is a non-device intensive procedure.

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 percent.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 20680 CY 2020 is $994.34.

The Medicare ASC reimbursement is divided by 2 = $497.17.

This number multiplied by the City Wage Index for Plano, Texas of 0.9747= $484.59.

Add these two together = $981.76.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $1,502.10.

The DWC finds the MAR for CPT code 20680 is $1,502.10. The respondent paid $1,827.02. The result is an overpayment of $324.92

C. HCPCS Code C9290 is not found on Addendum AA.

The DWC reviewed the submitted documentation and finds the requestor billed $175.10 for HCPCS code C9290. The respondent denied payment based upon a packaged service item. The requestor sought MFDR in the amount of $195.55 for C9290. The respondent did not maintain the denial and paid $195.54. The DWC finds the requestor is not due additional reimbursement.

D. HCPCS Code C1713

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 requestor billed $4,122.12 and was paid $4,122.00. The requestor is seeking MFDR for $412.13.

28 TAC §134.402(e) states,

> Regardless of billed amount, reimbursement shall be:
> (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
> (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

The DWC reviewed the submitted documentation and finds:

- Operative Patient Charge/Implant Record supports a charge of $600.00 for Matric 100 DBM Putty, 2.5cc.
- Stryker Invoice supports a charge of $3,522.12 for Micro lengthener and pins.
- Total for Implants = $4,122.12
- Per 28 TAC§134.402(f) the MAR for implantables is $4,534.33.
- The respondent paid $4,122.00.
- The difference between MAR and paid is $412.33. The requestor is seeking lesser amount of $412.13.

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 $557.89.

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 $557.89, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

		01/21/2021
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.