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
SOMPO AMERICA FIRE & MARINE INSURANCE CO

MFDR Tracking Number
M4-21-0615-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 30, 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: $1,910.32

RESPONDENT'S POSITION SUMMARY

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

SUMMARY OF FINDINGS

<table>
<tr><th>Dates of Service</th><th>Disputed Services</th><th>Amount In Dispute</th><th>Amount Due</th></tr>
<tr><td rowspan="3">July 6, 2020</td><td>Ambulatory Surgical Care Services (ASC)
CPT Code 23410</td><td>$0.00</td><td rowspan="3">$1,910.31</td></tr>
<tr><td>ASC Services for HCPCS Code C1763</td><td>$2,860.00</td></tr>
<tr><td>ASC Services for HCPCS Code C1713</td><td>$1,320.00</td></tr>
<tr><td>TOTAL</td><td></td><td>$1,910.32</td><td>$1,910.31</td></tr>
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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:
   - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
   - 223-Adjustement code for mandated federal, state or local law/regulation that I not already covered by another code and is mandated before a new code can be created.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - 6183-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.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 247- A payment or denial has already been recommended for this service.
   - 18-Exact duplicate claim/service.
   - B13-Previously paid payment for this claim/service may have been provided in a previous payment.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on July 6, 2020?

Findings

1. The Austin carrier representative for Sompo American Fire & Marine Insurance Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson received notice of this medical fee dispute on December 8, 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 $1,910.32 for ASC services rendered on July 6, 2020.

3. The respondent contends that the allowance of HCPCS code and C1713 and C1763 are included in the allowance of another service rendered on July 6, 2020.

   On the disputed date of service, the requestor billed CPT codes 23410, C1763 and C1713.

   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.

   28 TAC §134.402(d)(1) states,

   > Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

   28 TAC §134.402(f)(1)(B) states,

   > Reimbursement for non-device intensive procedures shall be: 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 DWC finds:

   - Per Medicare Policy HCPCS code C1713 and C1763 are status "N1" codes.

- CMS defines “N1” codes in Addendum DD1 as “Packaged service/item; no separate payment.”
- 28 TAC §134.402(F)(1)(b) allows for providers to request separate reimbursement for implants.
- Because the provisions of 28 TAC §134.402(F)(1)(B) are in conflict with Medicare policy, the DWCs rule takes precedence.
- The requestor requested separate reimbursement for HCPCS C1713 and C1763.
- The respondent’s denial of payment based upon unbundling is not supported per 28 TAC §134.402.

4. Per ADDENDUM AA, CPT code 23410 is a non-device intensive procedure.

   Per 28 TAC §134.402(f)(1)(B) the following formula was used to calculate the MAR:

   The Medicare ASC reimbursement for code 23410 is $2,803.36.

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

   This number multiplied by the City Wage Index for Plano, 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 DWC finds the MAR for CPT code 23410 is $4,234.88.

5. The requestor billed for the implantables with HCPCS codes C1713 and C1763.

   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.”

   Per 28 TAC §134.402(f)(1)(B) the following formula was used to calculate the MAR:

Implant (Per Implant Record)	No. Of Units	Cost	Cost + 10%
Perfect Passer Magnum Wire	1	Not supported	$0.00
Perfect Passer Connector	1	Not supported	$0.00
Bioinductive Implant with Arthroscopic	1	$2,600.00	$2,860.00
Bone Anchors	1	$800.00	$880.00
Tendon Anchors	1	$400.00	$440.00
TOTAL			$4,180.00

The DWC finds the MAR for the ASC services rendered on July 6, 2020 is $8,414.88. The respondent paid $6,504.57. The DWC finds the requestor is due additional reimbursement of $1,910.31.

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 $1,910.31.

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 $1,910.31, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

______________________	______________________	02/04/2021
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.