



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

GRAPEVINE SURGICARE

Respondent Name

TRUMBULL INSURANCE CO

MFDR Tracking Number

M4-21-1660-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

MAY 18, 2021

REQUESTOR'S POSITION SUMMARY

"At this time we are requesting that this claim paid in accordance with the 2021 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: \$3,790.76

RESPONDENT'S POSITION SUMMARY

"The provider correctly asserts that the charges on the bill should be paid at 'cost plus 10%', but they incorrectly charges for items that do not meet the State's definition of an implant, other than the anchor. These items are disposables/supplies which were not permanently implanted. The disposable items are not reimbursable as billed."

Response Submitted By: Foresight

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include January 27, 2021 with various ASC and HCPCS codes, and a TOTAL row.

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 February 22, 2021, 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:
 - 4458-Charges for surgical implants are reviewed separately by Foresight Medical.
 - W3-Additional payment made on appeal/reconsideration.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 96-Non-Covered charges.
 - TXIP- In order for implants to be considered for reimbursement, please note that provider must request separate reimbursement of implants in writing, including in the request (1) the manufacturer's invoice for cost of implantables, and (2) Certification that the amount billed represents the actual cost (net amount). Exclusive of rebates and discount(s) for the implantable. The certification shall include the following sentence "I hereby certify under penalty of law the following is the true and correct actual cost to the best of my knowledge."

Issues

Is the requestor due additional reimbursement ASC services rendered on January 27, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$3,790.76 for ASC services, HCPCS code C1713, rendered on January 27, 2021.
2. The respondent denied payment for HCPCS code C1713 based upon "96-Non-Covered charges."
28 TAC §133.307(d)(2)(H) requires the respondent to submit documentation "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

The respondent did not submit any Plain Language Notice in accordance with §124.2 in accordance with 28 TAC §133.307(d)(2)(H) to support denial based upon "96". The DWC finds the respondent did not support the "96" denial.
3. The respondent also denied reimbursement for HCPCS code C1713 based upon "TXIP- In order for implants to be considered for reimbursement, please note that provider must request separate reimbursement of implants in writing, including in the request (1) the manufacturer's invoice for cost of implantables, and (2) Certification that the amount billed represents the actual cost (net amount). Exclusive of rebates and discount(s) for the implantable. The certification shall include the following sentence "I hereby certify under penalty of law the following is the true and correct actual cost to the best of my knowledge."

28 TAC §133.10(f)(1)(W) states,

All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1)The following data content or data elements are required for a complete professional or non-institutional medical bill related to Texas workers' compensation health care: (W) supplemental

information (shaded portion of CMS-1500/field 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line.”

A review of the submitted medical bill finds the requestor did not indicate on fields 24d-24h a request for separate reimbursement for the implantables. Therefore, the requestor did not comply with 28 TAC §133.10(f)(1)(W).

The fee guideline for ASC services is found at 28 TAC §134.402.

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.

The DWC reviewed the submitted documentation and finds the implant cost certification was dated March 21, 2021. The original EOB indicates the carrier received the bill on February 2, 2021. The requestor’s certification is dated after this date. The DWC finds the requestor did not support that the implant cost certification was included with the billing as required by 28 TAC §134.402(g)(1)(B).

4. The respondent also denied reimbursement for C1713 based upon the fee guideline.

28 TAC §134.402(b) (6) states,

Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. “Medicare payment policy’ means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

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.

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 requestor did not submit the Implant record to support the implantables billed with CPT code C1713.

A review of the submitted invoices finds services that do not meet the definition for implantables per 28 TAC §134.402(b)(5). The respondent's denial of payment based upon the fee guideline is supported.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that 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

Signature

Medical Fee Dispute Resolution Officer

06/16/2021
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.