TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgicare at Blue Star

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-1351-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
March 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 7, 2021	29827	$0.00	$0.00
September 7, 2021	29826	$0.00	$0.00
September 7, 2021	64415	$313.38	$0.00
September 7, 2021	76942	$0.00	$0.00
September 7, 2021	C1713	$2615.26	$0.00
September 7, 2021	C9290	$212.88	$0.00
	Total	$765.40	$0.00

Requestor's Position

"The attached claim was processed and paid incorrectly. ...According to Texas Workers Compensation Rule 134.402, "Implantable devices are reimbursed at the provider cost plus 10%up to $1,000.00 per item or $2,000,00 per case. ...Please review the Claim, EOB, Operations Report and reprocess this claim."

Amount in Dispute: $765.40

Respondent's Position

"Texas Mutual review the dispute submitted by BAYLOR SURGICARE AT BLUE STAR. Review of the audit confirm that the initial bill for procedure code 29827 was paid that 235% (6795.44).

An appeal was received with a signed certification for implants. Audit confirm the bill was adjusted and paid the difference to equal 153% per separate reimbursement request of implants. Implants of 1-BCswivelock $920.00, 2-corkscrews @$816.00 @ $816.00 and 1-Bi-screw @483.00 x 10^ = $244.0.90. Reimbursement of implants less overpayment made at 235%. Total recommended payment $6865.17. C9290 – Bupivicaine inj _ Liposome was denied 892, 225. Documentation does not support injection. Liposome drug delivery is artificial disrupting biological membranes, therefore it is not considered an implant per Rule 134.402. Additionally, the bill submitted with the DWC60 packet shows a corrected claim, different from the appeal received and processed (see attachments). Change in cpt codes is not consistent with Rule 133.250 appeal for reconsideration, the corrected bill would be denied for untimely filing. No additional payment is due.

Response Submitted By: Texas Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307, sets out the procedures for resolving medical fee disputes.

2. 28 TAC §133.20 sets out the requirements of timely medical bill submission.

3. 28 TAC §134.402, sets out the fee guidelines for ASC services.

Denial Reasons

The insurance carrier reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804 this bill has been identified as a request for reconsideration
- 121 – Claim specific negotiated discount
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- DC3 – Additional reimbursement allowed after reconsideration for information call (888) 532-5246
- DC4 – No additional reimbursement allowed after reconsideration for information call

(888) 532-5246

- 225 – Submitted documentation does not support the service being gilled. We will re-evaluate upon receipt of clarifying information.
- 350 – Bill has been identified as a request for reconsideration or appeal
- 682 – Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions
- Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134. Subchapter (E) health facility fees.

Issues

1. Did the respondent raise a new issue?

2. Is the insurance carrier's denial based on documentation supported?

3. Did the requestor support submission of a corrected claim within requirements of Rule 133.20?

4. What rule is applicable to reimbursement?

5. Is Baylor Surgicare at Blue Star entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of code C9290 - Injection, bupivacaine liposome, 1 mg. In their position statement the insurance carrier states, "Liposome drug delivery is artificial disrupting biological membranes, therefore it not considered an implant per Rule 134.402." DWC Rule 28 TAC §133.307 (d)(2)(F) states in pertinent part the responses shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Review of the applicable explanation of benefits found insufficient evidence to support this denial reason was presented to the requestor prior to MFDR. The insurance carrier's position will not be considered in this review.

2. The requestor is seeking $212.88 for Code C9290. The insurance carrier denied as, "225 – The submitted documentation does not support the service being billed."

   Review of the submitted "Operative Report" found insufficient evidence to support the use of Injection, bupivacaine liposome, 1 mg. The insurance carrier's denial is supported. No additional payment is recommended.

3. The requestor included Codes 64415 and C1713 as part of their request for MFDR. Review of

the submitted medical bills found the original bill submitted to the insurance carrier did not contain Codes 64415 and C1713. The requestor included the "corrected claim" as part of their reconsiderations dated December 20, 2021, and February 22, 2022. Neither of these dates are within ninety-five days from the date of service, September 7, 2021. DWC Rule 133.20 (b) states in pertinent part, a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

The addition of a claim lines constitutes a new claim subject to timely filing. The requestor submitted insufficient evidence to support the timely submission of Code 64415 and C1713. No reimbursement is due.

4. The requestor is seeking medical fee dispute resolution for services provided as part of a surgery in an ambulatory surgical center in September 2021.

   The respondent contends that additional reimbursement is not due because payment of $6565.17 was made per the fee guideline.

   The fee guidelines for disputed services is found in 28 TAC §134.402(f)(1)(A) which 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:
   >
   > (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.
   >
   > (B) if an ASC facility 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.

   Review of the submitted medical bill found separate reimbursement for implants was requested.

   The following formula was used to calculate the MAR:

   The Medicare ASC reimbursement for code 29827 CY 2021 is $2,929.17.

   The Medicare ASC reimbursement is divided by 2 = $1,464.59.

This number multiplied by the CBSA Wage Index for Frisco Texas 0.9744= $1427.09.

Add these two together = $2,891.68.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153 percent = $3,081.45. This code is subject to multiple procedure rule discounting of 50% = $1,540.72.

The DWC finds the MAR for CPT code 29827 is $4,424.27.

The original medical bill contained a claim line for L8699 (1) unit. This was reviewed and paid by the carrier on January 18, 2022 in the amount of $69.73.

The insurance carrier included in their position statement a breakdown of implant calculation as follows; "IMPLANTS OF 1-BC SWIVELOCK $920.00, 2-CORKSCREWS @ $816.00 AND 1-BI-SCREW @ 483.00 X 10% = $2440.90. REIMBURSEMENT OF IMPLANTS LESS OVERPAYMENT MADE AT 235%. Total recommended payment $ 6865.17."

Review of the submitted implant log and invoices indicates:

Implant #	No. of Units	Invoice	Cost + 10%
Suture Anchor AR-1927BCT-475	1	$408.00	$448.80
Suture Anchor AR-1927BCT-475	1	$408.00	$448.80
Loop n Tack Tenodesis Implant System AR-1685BCSL	1	$920.00	$1012.00
Suture Anchor AR-23248CM	1	$483.00	$531.30
		Total	$2440.90

5. The DWC finds the MAR for the ASC services rendered on September 7, 202, is $6,865.17 ($2449,89 + $4,424.27). The respondent paid $6,795.44 at the time of reconsideration and $69.73 on January 18, 2022, for a total payment of $6865.17. The DWC finds the requestor is not due additional reimbursement.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Peggy Miller Medical Fee Dispute Resolution Officer	April 25, 2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.