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 Mansfield

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-22-1454-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
March 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 24, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 29888	$0.00	$0.00
	ASC CPT Code 29881	$0.00	$0.00
	ASC HCPCS Code C1762	$2,386.52	$0.00
	ASC HCPCS Code C1713	$1,742.40	$0.00
	Total	$3,567.42	$0.00

Requestor's Position

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

Amount in Dispute: $3,567.42

Respondent's Position

"The previous submission did not request for implantables to be reimbursed separately. There is only 1 unit billed for each implant charge, for a total of 2. The connective tissue for allograft

was not present on the invoices provided. Recommended allowance is $246.40 for the Tightrope ABS Button Roud 14mm."

Response Submitted by: Mitchell

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 §134.402, sets out the fee guidelines for ambulatory surgical care services.

Denial Reasons

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

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 618-The value of this service is packaged into the payment of another services performed on the same date of service.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 252-An attachment/other documentation is required to adjudicate this claim/service.
- 253-In order to review this charge please submit a copy of the invoice.
- 350-Bill has been identified as a request for reconsideration or appeal.
- 353-This charge was reviewed per the attached invoice.
- 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payment and contractual).

Issues

1. Is Service Lloyds Insurance Company's denial based on the implants being bundled to other service supported?

Findings

1. The requestor is seeking dispute resolution in the amount of $3,567.42 for the implantables with HCPCS Codes C1762 and C1713.

   The respondent denied reimbursement for HCPCS codes C1762 and C1713 based upon reason code, "618-The value of this service is packaged into the payment of another services performed on the same date of service." Upon receipt of this dispute, the requestor reconsidered position and issued payment of $246.40 for HCPCS code C1713.

The requestor wrote, “There is only 1 unit billed for each implant charge, for a total of 2. The connective tissue for allograft was not present on the invoices provided. Recommended allowance is $246.40 for the Tightrope ABS Button Roud 14mm.”

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

28 TAC §134.402(f)(2)(B) 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.

28 TAC §134.402 (g)(1)(A) and (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:
> (A) bill for the implantable on the Medicare-specific billing form for ASCs;
> (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.

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 documentation finds the following:

- The requestor did not indicate on the medical bill fields 24d-24h a request for separate reimbursement for the implantables.
- The implant cost certification was dated February 4, 2022. The original EOB indicates the carrier Post date of December 22, 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 initial billing as required by 28 TAC §134.402(g)(1)(B).
- he requestor submitted invoices but did not submit a copy of the implant record to support which implants were billed with codes C1762 and C1713; therefore, additional reimbursement is not recommended.

The DWC concludes the requestor did not comply with 28 TAC §134.402(g)(1)(B) and §133.10(f)(1)(W) for requesting separate reimbursement for implantables; therefore, the respondent's denial of payment for HCPCS codes C1762 and C1713 is supported.

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 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

		04/11/2022
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 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.