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**
North Garland Surgery Center

**Respondent Name**
TASB Risk Mgmt Fund

**MFDR Tracking Number**
M4-22-2174-01

**Carrier's Austin Representative**
Box Number 47

**DWC Date Received**
June 3, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| December 23, 2021 | 29828 | $1029.50 | $0.00 |
| December 23, 2021 | 29827 | $0.00 | $0.00 |
| December 23, 2021 | 29826 | $0.00 | $0.00 |
| December 23, 2021 | C1713 | $4628.80 | $0.00 |
| | **Total** | $1,072.05 "sic" | $0.00 |

## Requestor's Position

"At this time we are requesting that this claim paid in accordance with the 2022 Texas Workers Compensation Fee Schedule and Guidelines."

**Amount in Dispute:** $1,072.05

## Respondent's Position

"The previous allowance will be standing as this was paid at the correct markup of the documented implant."

**Response submitted by:** Mitchell International

# 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 centers.

## Denial Reasons

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

- 353 – This charge was reviewed per the attached invoice
- 45 – Charge exceeds fee schedule/maximum allowable for contracted/legislated fee arrangement
- 59 – Processed based on multiple or concurrent procedure rules
- P12 – Workers Compensation Jurisdictional fee schedule adjustment
- 790 – This charge was reimbursed in accordance to the Texas Medical fee guidelines
- 350 – Bill has been identified as a request for reconsideration or appeal

## Issues

1. Is the insurance carriers' reduction supported?
2. What rule applies for determining reimbursement for the disputed services?
3. Is the requester entitled to additional reimbursement?

## Findings

1. The requestor is seeking additional reimbursement of code 29828 and implants provided as part of a surgery rendered in December 2021 at an ambulatory surgical center. The insurance carrier reduced the payment based on fee schedule and submitted invoices.
2. DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.

DWC Rule 28 TAC §134.402 (f) states in pertinent part 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.

DWC Rule §134.402(e)(3) states in pertinent part, regardless of billed amount, reimbursement shall be the MAR as outlined in subception (f) of this section.

DWC 28 TAC Rule §134.402 (f)(1)(B)(i)(ii) states in pertinent parts, reimbursement for non-device intensive procedures shall be when 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 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 the Medicare ASC facility reimbursement amount multiplied by 153 percent.

The following formula was used to calculate the MAR:

Procedure Code 29828 has a payment indicator of G2. The following formula was used to calculate the MAR:

- The Medicare ASC reimbursement for code 29828 for applicable date of service is $2,929.17
- The Medicare ASC reimbursement is divided by 2 = $1,464.58.
- This number multiplied by the CBSA Wage Index for Garland, Texas of 0.9699 = $1,420.50.
- Add these two together = $1,464.58 + $1,420.50 = $2,885.08
- This code is subject to multiple procedure discount reduction of 50% or $1,442.54

The requestor is seeking separate reimbursement for the implants billed with HCPCS codes C1713.

- As stated above, per 28 TAC §134.402 (f)(1)(B) and (f)(2)(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:

- 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 the Medicare ASC facility reimbursement amount multiplied by 153 percent."

Per the Implant Record the following implants were used in the procedure:

| Implant Name | No of Units | Date of Invoice |
|---|---|---|
| BioComposite Swiveloche Suture Anchor, AR-2324BCT-2 | 77 | December 27, 2021 |
| BioCompsite Knotless Swivel AR-2324KBCCTT | 77 | January 6, 2022 |
| Suture Anchor, AR-2324BCCTT | 7 | January 6, 2022 |

The submitted operative report does not support the quantity of implants listed on implant log.

The submitted medical bill indicates "1" unit for code C1713.

The invoices submitted to support the cost are dated after the date of service in dispute of December 23, 2021.

The requestor did not support that additional payment is due on Code C1713. No additional payment is recommended.

The MAR of for code 29828 is $1,442.54 multiplied by 153% or $2,207.09. The insurance carrier paid $3,397.71. No additional payment is recommended.

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 | Medical Fee Dispute Resolution Officer | July 3, 2022<br>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, opción 3 o correo electronico CompConnection@tdi.texas.gov.