



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

METROCREST SURGERY CENTER

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-17-2449-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

APRIL 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: \$295.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include September 15, 2016 for CPT Code 28485 and HCPCS Code C1713, 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.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced 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 or appeal.
  - 252-An attachment/other documentation is required to adjudicate this claim/service.

## **Issues**

Is the requestor entitled to additional reimbursement for CPT code C1713 rendered on September 15, 2016?

## **Findings**

The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

28 Texas Administrative Code §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."

CPT code C1713 is defined as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

28 Texas Administrative Code §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."

28 Texas Administrative Code §134.402(f)(2)(B)(i) states, "The reimbursement calculation used for establishing the MAR 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."

A review of the submitted documentation finds that the requestor did not submit a copy of the invoice to support the cost of the implantables; therefore, reimbursement is not recommended.

## **Conclusion**

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

06/22/2017  
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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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.**