



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

Houston Metro-Ortho Spine

Respondent Name

National Fire Insurance Co

MFDR Tracking Number

M4-15-2439-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

April 6, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rule 134.402 of the Texas Administrative Code states the Ambulatory Surgical Center Fee Guideline. Section 134.402(e)(2) states the reimbursement shall be the maximum allowable amount under subsection (f), including any reimbursement for implantables. Rule 134.402(f) states the maximum allowable amount shall be the Medicare ASC reimbursement as listed in Addendum AA, ASC covered surgical procedures for CY 2008, or its successor. According to our records, HCPCS codes 64493, 64494, and 64495 are covered procedures and listed on Addendum AA for CY 2014. The denial reason of the benefits being included in payment for another service/procedure and not being paid separately are not valid because the procedures are covered and not bundled together. ...Therefore, it remains the Hospital's position the remainder of the bill should be paid and the Hospital should be reimbursed accordingly."

Amount in Dispute: \$168,135.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the bill was priced correctly and no further payment is due the provider. Carrier respectfully requests an order of no additional reimbursement due as the bill was properly processed in compliance with the Texas Labor Code and the Administrative Rules."

Response Submitted by: Brian J. Judis, 700 N. Pearl, Suite 245, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2014	63047, 63048, 64493, 64494, 64495	\$168,135.74	\$0.00

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 services in an Ambulatory Surgical Center.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment
 - 234 – This procedure is not paid separately
 - 193 – Original payment decision is being maintained
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - W3 – Request for reconsideration

Issues

1. What is the applicable rule pertaining to services in dispute?
2. Are the services in dispute allowed in the setting where the procedure was performed?
3. Are the insurance carrier’s reasons for denial or reduction of payment supported?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to services performed in an Ambulatory Surgical Center. 28 Texas Administrative Code §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.

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

Review of the ADDENDUM AA at cms.hhs.gov for 2014 finds;

1. 64493 – April 2014 Payment Indicator G2, April 2014 Payment Rate \$370.07
2. 64494 – April 2014 Payment Indicator N1, April 2014 Payment Rate (none)
3. 64495 – April 2014 Payment Indicator N1, April 2014 Payment Rate (none)

Review of the ADDENDUM EE – Surgical Procedures **Excluded** from Payment in ASCs for CY 2014 finds;

- a. 63047 – Removal of spinal lamina
- b. 63048 – Remove spinal lamina add-on

Pursuant to Rule 134.402 the codes eligible for reimbursement will be calculated based on applicable fee guidelines. The codes 63047 and 63048 were found to be excluded. The applicable rule is discussed below.

2. 28 Texas Administrative Code §134.402 (i) states,
 - (i) If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:
 - (1) The agreement may occur before, or during, preauthorization.
 - (2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

- (3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:
- (A) the reimbursement amount;
 - (B) any other provisions of the agreement; and (C) names, titles and signatures of both parties with dates.
- (4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).
- (5) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.”

Review of the submitted documentation finds no documentation to support requirements of Rule 134.402(i) therefore no additional payment can be recommended.

3. The insurance carrier denied disputed services 64494 and 64495, with claim adjustment reason code 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. 28 Texas Administrative Code §134.402 (d) requires that, “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...,” Review of the submitted information finds that the services in dispute have a payment indicator of N1 which states, “Packaged service/item; no separate payment made.” The carrier’s denial is supported.

4. 28 Texas Administrative Code §134.402 (f) 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 maximum allowable reimbursement for the service eligible for reimbursement is as follows:

Submitted Code	CMS Addendum AA ASC Reimbursement	Core based statistical Area	CBSA Wage Index	Calculation of Geographically adjusted Medicare ASC	Maximum allowable reimbursement calculation. Multiply the geographically adjusted Medicare ASC by the DWC payment adjustment factor of 235%
64493	\$370.07	26420	0.9975	$\$370.07 \div 2 = \185.04 Multiply this total by CBSA wage index $(\$185.04 \times 0.9975 = 184.58)$ Add both together $(\$185.04 + 184.58) = \369.62	$\$369.62 \times 235\% = \868.61

The total allowable for the services in dispute is \$868.81. The carrier previously paid \$3,936.46. No additional payment can be 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

Date

July , 2015

Signature

Director

Date

July , 2015

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.