



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

Fedex Freight Inc

MFDR Tracking Number

M4-15-2867-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Regarding the reconsideration request not being submitted timely as a reason for denial, reconsideration requests must be sent to the workers' compensation insurance carrier within 10 months of the date of service. The 10 month deadline passed on March 5, 2015. Our reconsideration request that was originally sent was sent on February 18, 2015. The USPS tracking number indicates it was delivered to the post office box on February 26, 2015, well within the 10 month deadline. The Hospital did submit its reconsideration request in a timely manner, and this denial reason is not applicable to this claim. Furthermore, the Hospital obtained authorization for the surgery performed. The Hospital performed the surgery while reasonably relying on the authorization as an indication the Hospital would be reimbursed properly."

Amount in Dispute: \$158,400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, 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

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5, 2014	63045, 63047	\$158,400.00	\$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

- 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:
 - W1– Workers compensation state fee schedule adjustment
 - 985 – Service is not allowable under Medicare’s ASC guidelines
 - W3 – Additional payment made on appeal/reconsideration
 - 5094 – DWC requires request for reconsideration or corrected claims to be submitted within 10 months of the date of service

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. 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. 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; or

(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:

- (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

The Medicare ASC reimbursement is discussed in the Medicare Claims Processing Manual, Chapter 14 - Ambulatory Surgical Centers, Section 20 - List of Covered Ambulatory Surgical Center Procedures states, “The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, the wage adjusted payment rates, and wage indices are available on the CMS Web site at: <http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html>.” Section 20.1 states, “The ASC list of covered procedures merely indicates procedures which are covered and paid for if performed in the ASC setting. It does not require the covered surgical procedures to be performed only in ASCs. The decision regarding the most appropriate care setting for a given surgical procedure is made by the physician based on the beneficiary’s individual clinical needs and preferences. Also, all the general coverage rules requiring that any procedure be reasonable and necessary for the beneficiary are applicable to ASC services in the same manner as all other covered services.”

The CMS, ASC web page, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html> contains the applicable addendums described as, “Ambulatory Surgical Center (ASC) Approved HCPCS Codes and Payment Rates. These files contain the procedure

codes which may be performed in an ASC under the Medicare program as well as the ASC payment group assigned to each of the procedure codes. The ASC payment group determines the amount that Medicare pays for facility services furnished in connection with a covered procedure.”

Review of ADDENDUM AA - - Final ASC Covered Surgical Procedures for CY 2014 (Including Surgical Procedures for Which Payment is Packaged) to Reflect the Extension of Current Medicare Physician Fee Schedule Payment Rates Created by the Protecting Access to Medicare Act of 2014 finds no listing for services in dispute codes 63045 and 63047.

Review of ADDENDUM EE - Surgical Procedures Excluded from Payment in ASCs for CY 2014, at the above web site finds;

- a. 63045 – Removal of spinal lamina
- b. 63047 – Removal of spinal lamina

The disputed codes 63045 and 63047 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.”

The requirements of Rule 134.402(i)(3)(A) were not met as no agreement was reached. Therefore no additional payment can be recommended.

3. The requestor states, “The hospital did submit its reconsideration request in a timely manner...” The Division found the carrier made an original adjudication and review where charges were denied as the services in dispute are excluded by the Medicare ASC payment policy. The carrier’s denial is supported, 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.

