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
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-15-3153-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We sent a clean claim with all required documentation requesting separate reimbursement for our implants and the carrier did not pay for on the implants. Implants are to be reimbursed at the providers cost plus 10% interest up to $1000.00 per item or $2000.00 per case."

Amount in Dispute: $7,632.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted an appeal with new information, and CV recommended an additional $3960.00. Per review of Risx-Facs, the payment recommendation was rejected."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 20, 2014	Ambulatory Surgical Care for HCPCS Code L8699 plus Interest	$7,632.44	$3,960.00

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, effective August 31, 2008, 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:
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

Is the requestor entitled to reimbursement for HCPCS code L8699?

Findings

On the disputed date of service, the requestor billed CPT codes 20902, 20680 and L8699. The respondents paid for codes 20902 and 20680 and are not in dispute. The respondent reduced payment for code L8699 based upon reason code "16."

HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) 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: (1) Reimbursement for non-device intensive procedures shall be: (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 Division reviewed the submitted medical bill and finds that the requestor did request separate reimbursement for the implantables; therefore, the disputed services were applicable to the reimbursement methodology outlined in 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii)."

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."

Section 413.011(b) of the Texas Labor Code states "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d).The commissioner shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c)and commissioner rules. This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."

28 Texas Administrative Code §134.402's preamble states "The Division is adopting minimal modifications to Medicare's reimbursement methodology to reflect use of separate reimbursement for surgically implanted devices in non-device intensive procedures to ensure injured employees have access to care, including surgery where surgically implanted devices are medically necessary."

According to *Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2015 (Including Ancillary Services for Which Payment is Packaged*), HCPCS Code L8699 has a payment indicator of "N1".

Addendum DD1, Final ASC Payment Indicators for CY 2015, defines payment indicator o "N1" as "Packaged service/item; no separate payment made."

Even though HCPCS code L8699 has a payment indicator of N1, Section 413.011(b) of the Texas Labor Code, 28 Texas Administrative Code §134.402(d), and it's preamble, make the exception to Medicare's policies and allow separate reimbursement for implantables in non-device intensive procedures.

A review of the submitted documentation finds that the requestor submitted a copy of an invoice that supports

billed service at a cost to the provider of $3,600.00. Therefore, the respondent's denial is not supported and reimbursement is recommended.

Per 28 Texas Administrative Code §134.402(f)(1)(B)(i), $3,600.00 plus 10% equals $3,960.00. The respondent paid $0.00. As a result, reimbursement of $3,960.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,960.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,960.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

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Authorized Signature

		July 9, 2015
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 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.