TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Metro-Ortho Spine

Respondent Name
TPCIGA for RELIANCE NATIONAL

MFDR Tracking Number
M4-15-3474-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
June 19, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital is entitled to reimbursement because it provided the medically necessary, authorized procedure. The Hospital received authorization for the surgery, and reasonably relied on the authorization for payment. Furthermore, the Hospital attempted to reach a fee agreement with TPCIGA, but the adjuster refused. The Hospital took all the reasonably necessary steps to be paid for the surgery, and should be reimbursed accordingly."

Amount in Dispute: $52,983.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TPCIGA contacted the medical provider on Tuesday, July 7, 2015 and spoke with Ryan Brawner to further explain the incorrect coding issue. TPCIGA requested the provider to submit a bill with proper coding. To date, TPCIGA has not received a call back from the provider, nor have we received a bill with correct coding. TPCIGA will promptly process the providers bill once a corrected coded bill has been received."

Response Submitted by: Texas Property & Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2014	63047, L8699	$52,983.00	$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

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:
   - P20 – Service not paid under jurisdiction allowed outpatient facility fee schedule
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

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?

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, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html - - 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 service in dispute code 63047 or L8699.

Review of ADDENDUM BB - Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2014 (Including Ancillary Services 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, at the above web site for 2014 finds;

1. L8699 – Payment Indicator N1
2. N1 – Packaged service/item; no separate payment made.

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

a. 63047 – Removal of spinal lamina

The disputed code 63047 was 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 respondent stated, "…the Hospital attempted to reach a fee agreement with TPCIGA, but the adjuster refused." 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 insurance carrier denied disputed service L8699, 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.

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

		September 23, 2015
Signature	Medical Fee Dispute Resolution Officer	Date
		September 23, 2015
Signature	Director	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.