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
STONE OAK SURGERY CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-15-4248-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 31, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is our position that this claim should be paid an additional $28,523.11 as the claim was underpaid per TX WC ASC reimbursement guidelines."

Amount in Dispute: $60,658.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It was determined that no additional payment is owed to the provider."

Responses Submitted By: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 15, 2014	Ambulatory Surgical Care for CPT Code 63685	$41,974.02	$1,754.99
	Ambulatory Surgical Care for CPT Code 63650	$9,342.48	
	Ambulatory Surgical Care for CPT Code 63650-59	$9,342.48	
	HCPCS Code L8687, L8680, L8689, L8681, L8699 and 99070	$0.00	
TOTAL		$60,658.98	$1,754.99

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - 889-Device-intensive procedure added to ASC list in CY 2008 or later, paid at adjusted rate.
    - 59-Processed based on multiple or concurrent procedure rules.
    - Previous recommended history on DCN(s).
    - 148-This procedure on this date was previously reviewed.
    - 18-Duplicate claim/service.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for services rendered on December 15, 2014?

Findings

According to the explanation of benefits, the respondent paid for CPT codes 63685, 63650, and 63650-59 based upon reason code "P12."

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 63685 is described as "Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling."
- CPT code 63650 is described as "Percutaneous implantation of neurostimulator electrode array, epidural"

The requestor wrote in the position summary that separate reimbursement for the implantables was requested; therefore, 28 Texas Administrative Code §134.402(f)(2)(B)(i) and (ii) applies to the services in dispute.

28 Texas Administrative Code §134.402(f)(2)(B)(i) and (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: (2) Reimbursement for device intensive procedures 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; and (ii) the ASC service portion multiplied by 235 percent."

A. To determine the MAR for codes 63685 is a four-step process:

Step 1-Gather factors:

- According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for code 63685 is $17,232.90.
- The device dependent APC offset percentage for code 63685 is 86%.
- According to Addendum AA found on CMS website, CPT code 63685 has a Medicare fully implemented ASC reimbursement of $16,172.35.
- The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for San Antonio, Texas is 0.8911.

Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage:
$17,232.90 multiplied by 86% = $14,820.29.

Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 63685. This step requires calculations:

- The Medicare fully implemented ASC reimbursement rate of $16,172.35 is divided by 2 = $8,086.17.
- This number multiplied by the City Wage Index for San Antonio, TX $8,086.17 X 0.8911 = $7,205.58.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement = $15,291.75.

Step 4- To determine the service portion:

- Subtract the device portion from the geographically adjusted Medicare ASC reimbursement $15,291.75 minus $14,820.29 = -$471.46
- Multiply the service portion by the DWC payment adjustment factor of 235% $471.46 multiplied by 235% = $1.107.93.

B. To determine the MAR for codes 63650 and 63650-59 is a four-step process:

Step 1-Gather factors:

- According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for code 63650 is $4,626.50.
- The device dependent APC offset percentage for code 63650 is 55%.
- According to Addendum AA found on CMS website, CPT code 63650 has a Medicare fully implemented ASC reimbursement of $3,691.78.
- The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for San Antonio, Texas is 0.8911.

Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage:
$4,626.50 multiplied by 55% = $2,544.57.

Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 63650. This step requires calculations:

- The Medicare fully implemented ASC reimbursement rate of $3,691.78 is divided by 2 = $1,845.89.
- This number multiplied by the City Wage Index for San Antonio, TX $1,845.89 X 0.8911 = $1,644.87.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement = $3,490.76.

Step 4- To determine the service portion:

- Subtract the device portion from the geographically adjusted Medicare ASC reimbursement $3,490.76 minus $2,544.57 = $946.19
- Multiply the service portion by the DWC payment adjustment factor of 235% $946.19 multiplied by 235% = $2,223.54.

The requestor billed for two units of code 63650; therefore, $2,223.54 X 2 = $4,447.08.

Per 28 Texas Administrative Code §134.402(e)(2) states "Regardless of billed amount, reimbursement shall be: if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables."

To determine the implant portion:

CODE	Implant Cost	MAR
L8687	$12,600.00	$13,600.00
L8680	$5,900.00	$6,490.00
L8689	$700.00	$770.00
L8681	$800.00	$880.00
L8699	$150.00	$165.00
TOTAL	$20,150.00	$21,905.00

On the disputed date of service, the requestor also billed $495.00 for CPT code 99070 defined as supplies and materials. CPT code 99070 has an ASC payment indicator of "IT" because the items are bundled to the ASC payment for the procedure. The respondent paid $495.00; therefore, additional reimbursement is not recommended.

Per 28 Texas Administrative Code §134.402(f)(2)(B)(i) and (ii), the MAR for services rendered on December 15, 2014 is $27,955.01. The respondent paid $26,200.02. As a result, additional reimbursement of $1,754.99 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 $1,754.99.

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 $1,754.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/3/2015
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.