



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

STONEGATE SURGERY CENTER

Respondent Name

TRAVIS COUNTY

MFDR Tracking Number

M4-16-1378-01

Carrier's Austin Representative

Box Number 38

MFDR Date Received

JANUARY 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim did not pay correctly as line 3 was denied because 'the benefit for this service is included in the payment for another service.' We billed 24342 to allow at 153% of Medicare fee schedule, which means we are expecting reimbursement for the implant C1713 and Q4139 per TDI guidelines. The reimbursement for these codes are 24342 at 3083.01, C1713 at \$935.00 and Q4139 at \$1980.00. Since we already received a payment of \$5670.35 we are expecting an additional payment of \$327.66."

Amount in Dispute: \$327.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2015	Ambulatory Surgical Care for HCPCS Code Q4139	\$327.66	\$327.64

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.
- 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97-The benefit for this service is included in the pymt/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.
- W3-Additional payment made on appeal/reconsideration.

Issues

1. Is the allowance for HCPCS code Q4139 included in the allowance of another service/procedure?
2. Does HCPCS code Q4139 meet the definition of implantable?
3. Does documentation support separate reimbursement for implantables?
4. Is the requestor entitled to additional reimbursement?

Findings

1. On the disputed date of service, the requestor billed CPT codes 24342-LT, C1713 and Q4139. The respondents paid for codes 24342-LT and C1713 and are not in dispute. The respondent denied payment for code Q4139 based upon reason code "97."

HCPCS code Q4139 is defined as "Amniomatrix or biodmatrix, injectable, 1 cc."

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."

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 Q4139 has a payment indicator of "N1".

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

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."

Even though HCPCS code Q4139 has a payment indicator of N1, Section 413.011(b) of the Texas Labor Code, 28 Texas Administrative Code §134.402(d), and its preamble, make the exception to Medicare's policies and allow separate reimbursement for implantables.

2. 28 Texas Administrative Code §134.402(b)(5) states "Implantable" means an object or device that is surgically:
 - (A) implanted,
 - (B) embedded,
 - (C) inserted,
 - (D) or otherwise applied, and
 - (E) related equipment necessary to operate, program, and recharge the implantable."

The requestor billed for code Q4139 because the Amniox allograft was applied to the claimant's tendon; therefore, the requestor supported Q4139 is an implantable that is eligible for reimbursement.

3. The requestor noted that “We billed 24342 to allow at 153% of Medicare fee schedule, which means we are expecting reimbursement for the implant C1713 and Q4139 per TDI guidelines. The reimbursement for these codes are 24342 at 3083.01, C1713 at \$935.00 and Q4139 at \$1980.00. Since we already received a payment of \$5670.35 we are expecting an additional payment of \$327.66.”

The Division reviewed the submitted explanation of benefits and finds that the respondent paid for codes 24342-LT and C1713. The Division finds that the requestor supported position that separate reimbursement for the implantables was requested because separate payment for code C1713 was made; therefore, the disputed service is applicable to the reimbursement methodology outlined in 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii).

4. 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.”

A review of the submitted documentation finds that the requestor submitted copies of invoices from Medical Management Solutions, LLC and Arthrex that lists the implantables used in the surgery.

The Division reviewed the invoices and finds the MAR for the implantables per 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) is:

Code	Unit Price	No. of Units	MAR
C1713	\$850.00	1	\$935.00
Q4139	\$1,800.00	1	\$1,980.00
TOTAL			\$2,915.00

To determine the maximum allowable reimbursement (MAR) the Division gathered the following factors to be used in the calculations:

According to Addendum AA, CPT code 24342 is a non-device intensive procedure.

The City Wage Index for Austin, Texas is 0.9545.

The fully implemented ASC relative payment weight for code 24342 CY 2015 is \$2,061.95.

To determine the geographically adjusted Medicare ASC reimbursement for code 24342:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = \$1,030.97

This number multiplied by the City Wage Index \$984.06.

Add these two together = \$2,015.03.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153%:

\$2,015.03 X 153% = \$3,082.99.

To determine if additional reimbursement is due for the ASC services rendered on April 24, 2015 add the MARs for the services = \$5,997.99. The respondent paid \$5670.35. The difference between the MAR and amount paid is \$327.64; this amount is recommended for additional reimbursement.

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 \$327.64.

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 \$327.64 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	03/31/2016
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.