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
ELITE SURGERY AT RIVER OAKS

Respondent Name
MID-CENTURY INSURANCE COMPANY

MFDR Tracking Number
M4-16-1521-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
February 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Elite Surgery at River Oaks was underpaid for the above referenced claim. The underpayment was recognized when VMD Mediquip's bill was denied by Corvel for 'the ASC did not indicate separate reimbursement for implants.' I have attached VMD Mediquip's EOR and Elite surgery at River Oaks EOR. The facility was not paid for the implant and was, actually, underpaid for the date of service according to the Texas Worker's Compensation fee schedule. . . Farmers should have paid $30,703.29 which is 235% of the Medicare rate."

Amount in Dispute: $13,754.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary, February 16, 2016: "Respondent properly calculated the amount of reimbursement owed under the fee guideline. Therefore, Requestor is not entitled to additional reimbursement."

Response Submitted by: Stone Loughlin & Swanson

Respondent's Position Summary, February 25, 216: "it appears the Requestor multiplied the *Adjusted ASC Payment rate of $13,065.23* by the conversion factor of 235%. However, this is incorrect. This amount includes the Device's portion of the payment and per the rule above, you do NOT multiple the Device portion by 235% - ONLY the Service portion."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2015	Ambulatory Surgery: Procedure Code 62362	$13,754.72	$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 medical fee guideline for ambulatory surgery centers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation State Fee Schedule Adj
   - B13 – Payment for service may have been previously paid
   - W3 – Appeal/Reconsideration.

Issues

1. Did the health care provider request separate reimbursement for implantables?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The health care provider states:

   > The underpayment was recognized when VMD Mediquip's bill was denied by Corvel for 'the ASC did not indicate separate reimbursement for implants.' I have attached VMD Mediquip's EOR and Elite surgery at River Oaks EOR. The facility was not paid for the implant and was, actually, underpaid for the date of service according to the Texas Worker's Compensation fee schedule.

   Per the EOB, CorVel received the ASC facility bill on June 25, 2015. No information was presented to indicate that separate reimbursement for implantables was requested by the facility or would be requested under separate cover at a later date from a surgical implant provider. The explanation of benefits indicates that the ASC facility bill was processed and paid on July 6, 2015.

   The reconsideration EOB for the surgical implant provider indicates CorVel received the surgical implant provider's reconsideration request on August 26, 2015. This date is after the date CorVel had already processed and paid the facility's surgery bill at the 235% rate, inclusive of implantables. Information was not presented regarding the date the surgical implant provider submitted their original bill. Based on the information provided, a request for separate reimbursement of implantables is not supported.

2. This dispute regards procedure code 62362, a device-intensive ambulatory surgery with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(f)(2), which requires that the 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 Federal Register, or its successor.

   The following minimal modifications apply:

   (2) Reimbursement for device intensive procedures shall be:
   (A) the sum of:
   (i) the ASC device portion; and
   (ii) the ASC service portion multiplied by 235 percent; or
   (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.

   The submitted documentation did ***not*** support that the health care provider requested separate reimbursement for implantables; therefore, the applicable rule for reimbursement is §134.402(f)(2)(A).

3. Reimbursement is calculated as follows:

- Procedure code 62362, service date June 4, 2015, has status indicator J8 denoting a device-intensive procedure reimbursed in accordance with Rule §134.402(f)(2). Per Addendum AA, the payment rate for this procedure is $13,241.34. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $6,620.67 each. The labor-related half is geographically adjusted by multiplying it by the annual wage index for this facility's location of 0.9734. The adjusted labor portion is $6,444.56. This amount is added back to the non-labor half. The sum is the Medicare ASC facility rate of $13,065.23. The device-offset percentage of 0.8100, from Medicare's Table of ASC Designated Device-Intensive Procedures, is multiplied by the OPPS rate for this procedure code as listed in Addendum B of $15,572.43, yielding an ASC device portion of $12,554.49. This amount is subtracted from the facility rate, leaving the service portion of $510.74. This amount multiplied by the Division conversion factor of 235% is $1,200.24. The device portion is added back to the adjusted service portion for a total MAR of $13,754.73.

The total allowable reimbursement for the services in dispute is $13,754.73. The insurance carrier has paid $13,754.72. Additional payment is not 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.

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 not entitled to additional payment for the services in dispute.

Authorized Signature

	Grayson Richardson	March 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.