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
NORTH TEXAS SURGERY CENTER

Respondent Name
TEXAS PROPERTY & CASUALTY INSURANCE GUARANTY ASSOCIATION FOR LEGION INSURANCE COMPANY

MFDR Tracking Number
M4-16-2619-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
April 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the carrier continues to deny for timely filing. We have appealed numerous times giving the carrier proof that this claim was filed timely ye they have denied every time."

Amount in Dispute: $56,167.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Legion Insurance Companies was impaired on October 25, 2002. At this time the Texas Property and Casualty Insurance Guaranty Association (TPCIGA) began handling the claim. TPCIGA will be processing the bill in question according to the Division of Workers' Compensation Fee Guidelines and Article 28.21C. A completed Explanation of Benefits will be submitt3ed to the Division upon completion of the audit."

Response Submitted by: Texas Property and Casualty Insurance Guaranty Association (TPCIGA)

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2015	Ambulatory surgical services with separate reimbursement of implantables requested	$56,167.36	$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:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – [no description of this payment adjustment code was found in the submitted materials.]

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended reimbursement for the disputed surgical services?
3. What is the recommended reimbursement for the disputed implantable items?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED" 28 Texas Administrative Code §133.20(b) requires that "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Review of the submitted information finds that the requestor submitted documentation to support timely filing of the medical bills with the insurance carrier. The respondent did not maintain this defense or denial reason in their response to MFDR. Accordingly, the Division concludes that this denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute regards facility reimbursement of an ambulatory surgery center subject to 28 Texas Administrative Code §134.402(f), which requires that the calculation used to establish 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.

   Per §134.402(f)(2)(B), if an ASC facility requests separate reimbursement for an implantable, reimbursement for device intensive procedures 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.

   Reimbursement is calculated as follows:

   - Procedure code 63685, service date August 14, 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 $20,813.64. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $10,406.82 each. The labor-related half is geographically adjusted by multiplying it by the annual wage index for this facility's location of 0.9703. The adjusted labor portion is $10,097.74. This amount is added back to the non-labor half. The sum is the Medicare ASC facility rate of $20,504.56. The device-offset percentage of 0.8700, 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 $26,162.39, yielding an ASC device portion of $22,729.88. This amount is subtracted from the facility rate, leaving a *negative* service portion of –$2,225.32. This amount multiplied by the Division conversion factor of 235% is –$5,229.50.

- Procedure code 95971, service date August 14, 2015, represents electronic analysis of an implanted neurostimulator pulse generator system. Per Medicare payment policy, this procedure is a non-surgical service that is not covered when performed in an ambulatory surgery center. Per 28 Texas Administrative Code §134.402(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 if criteria are met as described in the rule; however, no documentation was presented to support an agreement between the parties to allow an ASC setting for this procedure in accordance with the requirements of the rule. Consequently, additional reimbursement cannot be recommended.

3. Additionally, the requestor asked for separate reimbursement of implantable items. Per §134.402(f)(2)(i), if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for that item shall be "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." Review of the submitted documentation finds the following implantable items:

   - Procedure code L8687, service date August 14, 2015, represents a Precision Spectra implantable pulse generator device. Review of the submitted documentation finds certification to support that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable items in accordance with the requirements of 28 Texas Administrative Code §134.402(g)(B). The submitted invoices support that the cost to the provider for the generator kit was $28,285.00. 10% of this amount exceeds the $1,000 limit per billed item add-on; therefore, the add-on for this item is $1,000, for a total reimbursement of $29,295.00.

   - Additionally, the injured worker was provided an external remote control to operate the generator. While this device is not itself implanted, per Rule §134.402(b)(5)(E), the meaning of "Implantable" includes: "related equipment necessary to operate, program, and recharge the implantable." This device meets the definition of related equipment necessary to operate the implanted pulse generator, and is therefore reimbursable separately as an implantable item. The invoices support cost to the provider for the remote control kit of $900.00. 10% of this amount is 90.00, for a total reimbursement of $990.00

   - Procedure code L8689, service date August 14, 2015, represents an external recharging system for battery (internal) for use with implantable neurostimulator, which per §134.402(b)(5)(E), also meets the definition of related equipment necessary to recharge the implantable, and is therefore itself reimbursable separately as an implantable item. The invoices support a cost to the provider of $3,665.00. 10% of this amount is $366.50, for total reimbursement of $4,031.50

   - Per §134.402(f)(2)(i), if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for that item shall be "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."

   The total net invoice amount (exclusive of rebates and discounts) is $32,850.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,456.50. The total recommended reimbursement amount for the implantable items is $34,306.50.

4. Total reimbursement for the implantables (including add-ons) of $34,306.50 less the negative amount of the reimbursement for the device intensive surgery of –§5,229.50, results in a maximum allowable reimbursement of $29,077.00 for the services in dispute. The insurance carrier has paid $32,850.00. No additional payment is 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 on 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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 24, 2016
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	August 24, 2016
Signature	Director of Medical Fee Dispute Resolution	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.