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
SPINECARE, LLP

Respondent Name
CITY OF CORPUS CHRISTI

MFDR Tracking Number
M4-16-3042-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
June 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Spinecare is an Ambulatory Surgical Center (ASC). The carrier did not process the claim at the correct MAR."

Amount in Dispute: $2,727.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2016	Ambulatory Surgical Services, Procedure Code: 64635	$2,727.40	$1,879.55

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 Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged June 14, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEWIT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Are the insurance carrier's adjustment reasons supported?
2. What is the recommended reimbursement for the disputed health care?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced payment with reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment."

   The requestor states that "The carrier did not process the claim at the correct MAR."

   After acknowledging receipt of notification of the request for medical fee dispute resolution, the respondent did not submit a position statement for consideration in this review, or documentation to support the payment reductions to the medical bill.

   This review is based on the documentation presented by the parties available at the time of review.

   The submitted documentation does not support that payment was adjusted according to the appropriate Texas workers' compensation fee schedule for the ASC facility services billed. The insurance carrier's payment adjustment codes are not supported. Accordingly, reimbursement will be reviewed per applicable Division rules and fee guidelines.

2. This dispute regards the facility services of an ambulatory surgery center with reimbursement subject to 28 Texas Administrative Code §134.202(f), 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:

   (1) Reimbursement for non-device intensive procedures shall be:
   (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent

   Reimbursement is calculated as follows:

   - Procedure code 64635-RT, service date March 1, 2016, represents a paravertebral facet joint denervation (right side). Per Addendum AA, the payment rate for this procedure is $778.70. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $389.35 each. The labor-related half is geographically adjusted by multiplying it by the annual wage index for this facility's location of 0.8533. The adjusted labor portion is $332.23. This amount is added back to the non-labor half. The sum is the Medicare ASC facility rate of $721.58. This amount multiplied by the Division conversion factor of 235% is $1,695.71. This procedure is subject to Medicare's multiple procedure payment reduction policy. The first

unit of the highest paying procedure is paid at 100%; all other such services are paid at 50%. This procedure is the highest paying procedure performed this date. The total reimbursement for 1 unit is $1,695.71.

- Procedure code 64635-LT, service date March 1, 2016, represents a paravertebral facet joint denervation (left side). Per Addendum AA, the payment rate for this procedure is $778.70. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $389.35 each. The labor-related half is geographically adjusted by multiplying it by the annual wage index for this facility's location of 0.8533. The adjusted labor portion is $332.23. This amount is added back to the non-labor half. The sum is the Medicare ASC facility rate of $721.58. This amount multiplied by the Division conversion factor of 235% is $1,695.71. This procedure is subject to Medicare's multiple procedure payment reduction policy. The first unit of the highest paying procedure is paid at 100%; all other such services are paid at 50%. This is a second unit of the highest paying procedure, which is subject to multiple procedure payment reduction of 50%. The total reimbursement for this unit is $847.86.

3. The total allowable reimbursement for the services in dispute is $2,543.57. The insurance carrier has paid $664.02. The amount due to the requestor is $1,879.55.

Conclusion

Based on a preponderance of the evidence presented at medical fee dispute resolution, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,879.55.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,879.55, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	July 28, 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.