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
METROCREST SURGERY CENTER

Respondent Name
EMPLOYERS PREFERRED INS CO

MFDR Tracking Number
M4-17-2921-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
JUNE 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2017 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $2,520.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An additional payment in the amount of $1,683.55 was made on 6/6/17. Please see the attached EOR. Per NCCI edits, CPT 64415 cannot be billed with 29807 under any circumstances. NCCI validation results have been provided. CPT 76942 and HCPCS codes C1713 and L8699 all have Medicare payment status indicators of N1 meaning non-reimbursable. Therefore we feel that no additional payment is due.

Response Submitted By: Conduent

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2017	Ambulatory Surgical Care for CPT Code 29807	$1,985.74	$0.00
	Ambulatory Surgical Care for CPT Code 64415	$262.88	$0.00
	Ambulatory Surgical Care for CPT Code 76942	$0.00	$0.00
	Ambulatory Surgical Care for HCPCS Code C1713	$214.00	$0.00
	Ambulatory Surgical Care for HCPCS Code L8699	$57.60	$0.00
Total		$2,520.22	$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 §133.305 sets out the general Medical Dispute Resolution guidelines.
1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - T13-Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 10 months from the date of service.
   - 851-The allowance was adjusted in accordance with multiple procedure rules and/or guidelines.
   - 5211-Nurse audit has resulted in an adjusted reimbursement.
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 4915-The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packed or excluded from payment.
   - 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we re recommending further payment to be made for the above noted procedure code.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 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. What is the applicable rule for determining reimbursement of the disputed services?

2. Is the requestor due additional reimbursement for code 29807?

3. Is the respondent's denial of payment supported for code 64415?
4. Is the requestor due additional reimbursement for HCPCS code L8699 and C1713?

Findings

1. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

2. Per the Table of Disputed Services, the requestor is seeking additional reimbursement of $1,985.74 for code 29807.

   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."

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 29807 is a non-device intensive procedure.

The City Wage Index for Carrollton, Texas is 0.9895.

The fully implemented ASC relative payment weight for code 29807 CY 2017 is $2,647.21.

To determine the geographically adjusted Medicare ASC reimbursement for code 29807:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = $1,323.60

This number multiplied by the City Wage Index $1,309.70.

Add these two together = $2,633.30.

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

$2,633.30 X 153% = $4,028.94.

The respondent explanation of benefits that support payment of :

- $2,049.13 issued on 3/2/2017
- $1,683.55 issued on 6/2/2017
- $6,197.35 issued on 6/21/2017

As a result, additional reimbursement is not recommended.

3. According to the submitted explanation of benefits, the respondent denied reimbursement for 64415 based upon "T13-Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 10 months from the date of service."

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

   The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives***.

   28 Texas Administrative Code § 133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals. The Division finds that due to the unresolved medical necessity issues, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308

4. The requestor is seeking additional reimbursement for HCPCS code C1713 and L8699. Based upon the Table of Disputed Services, the respondent paid $2,144.00 for code C1713 and $576.00 for L8699.

   The respondent contends that reimbursement is not due because "CPT 76942 and HCPCS codes C1713 and L8699 all have Medicare payment status indicators of N1 meaning non-reimbursable. Therefore we feel that no additional payment is due."

   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 Codes C1713 and L8699 have a payment indicator of "N1".

   Addendum DD1, Final ASC Payment Indicators for CY 2017, defines payment indicator "N1" as "Packaged service/item; no separate payment made."

   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."

   28 Texas Administrative Code §134.402 (d)(1) states, "Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program."

   The exception to Medicare's policies for HCPCS codes C1713 and L8699 is found in 28 Texas Administrative Code §134.402(d)(1) and its' preamble.

   A review of the submitted documentation finds that the requestor did not submit the manufacturer's invoice to support the cost of the implantables, HCPCS codes C1713 and L8699. As a result, additional reimbursement cannot be 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 entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/21/2017 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.