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
TEXAS SURGICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-3079-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This clean claim was billed requesting the surgical procedure be paid at 153% of CMS with separate reimbursement for our implants. **According to Texas Workers Compensation Rule 134.402, 'Implantable devices are reimbursed at the providers cost plus 10% up to $1,000.00 per item or $2,000.00 per case..**' In this case our implants cost more than was paid on the claim. **Manufacturer's invoices are attached**… At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $212.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed codes 25337 and L8699. Texas Mutual paid the full MAR `for code 25337. Review of ASC Appendix DD1 Shows code L8699 has status indicator N1 that stated 'Packaged service/item; no separate payment made.' Therefore, Texas Mutual declined to issue payment. The requestor provides no basis for its assertion it should be paid for L8699."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2016	Ambulatory Surgical Care Services for CPT Code 25337	$0.00	$0.00
	HCPCS Code L8699	$212.91	$0.00
TOTAL		$212.91	$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 a medical fee dispute.
2. 28 Texas Administrative Code §133.10 sets out the general medical billing procedures.
3. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

    - CAC-P12-Workers compensation jurisdictional fee schedule adjustment.
    - CAC-97-The benefit for this service is included in the payment/allowance for another service procedure that has already been adjudicated.
    - 217-The value of this procedure is included in the value of another procedure performed on this date.
    - 305-The implant is included in the billing and is reimbursed at the higher percentage calculation.
    - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
    - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor request implants in accordance with Division guidelines?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute? Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking separate reimbursement for implantables that were provided as part of the ambulatory surgical care services in dispute. The requestor in this case argues that it should have been paid separately for the implanatables and is due an additional reimbursement of $212.91.
2. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

    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."

    The definitions for the codes billed are:

    - CPT code 25337 is defined as "Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization (eg, tendon transfer, tendon graft or weave, or tenodesis) with or without open reduction of distal radioulnar joint."
    - HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

    According to 28 Texas Administrative Code §134.402 (f), "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:

28 Texas Administrative Code §134.402 (f)(1)(A) and (B) states, "Reimbursement for non-device intensive procedures shall be:

(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or

(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."

28 Texas Administrative Code §133.10(f)(1)(W) requires that the facility use a specific field on the CMS-1500 to make a request for separate reimbursement: "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (w) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line."

Review of the submitted medical bills finds that neither the original billing, nor the bills submitted for reconsideration contain the required data in fields 24d-24h. For that reason, the Division finds that the carrier in this case correctly deferred to the higher 235% rate outlined in §134.402(f)(1)(A) as noted in their position statement. Therefore, the calculation of the maximum allowable reimbursement is discussed below.

3. To determine if the requestor was appropriately reimbursement for code 25337 a non-device intensive procedure, the division refers to 28 Texas Administrative Code §134.402(f)(1)(A),

The Medicare ASC reimbursement rate for code 25337 CY 2016 is $1,339.58.

The City wage index for Midland, Texas is 0.9196.

To determine the geographically adjusted Medicare ASC reimbursement for non-device intensive procedures use the following formula:

- The Medicare ASC reimbursement rate of $1,339.58 is divided by 2 = $669.79.
- This number multiplied by the City Wage Index $669.79 X 0.9196 = $615.93.
- Add these two together = $1,285.72.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%.

$1,285.72 X 235% = $3,021.44.

The respondent paid $3,021.46. 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

		7/11/2017
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.