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
BON SECOURS SURGERY CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-18-0879-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
DECEMBER 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Texas Division of Workers' Compensation, when medical services are rendered by an out-of-state medical provider, there is not necessarily a statute or guideline I place clarifying whether payment should be based upon Texas' fee schedule or based upon the payment guidelines of the state in which services were rendered. It's our contention that payment should be made pursuant to Virginia's charge-based prevailing community rate metric ('PCR') and not the Texas fee schedule."

Amount in Dispute: $25,818.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual adjudicated the bill consistent with Rule 134.402. Further, there is no provision in the Labor Code or in the Rule itself waving application of this Rule in the face of an out of state ASC. No additional payment is due, certainly not billed charges.

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2017	Ambulatory Surgical Care Services (ASC)	$25,818.85	$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, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 205-This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
   - CAC-236-This billing code is not compatible with another billing code provided on the same day according to NCCI or workers compensation state regulations/fee schedule requirements.
   - CAC-59-Processed based on multiple or concurrent procedure rules (For example multiple surgery or diagnostic imaging, concurrent anesthesia).
   - 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 this billing and is reimbursed at the higher percentage calculation.
   - 435-Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
   - 615-Payment for this service has been reduced according to the Medicare multiple surgery guidelines.
   - 662-Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 723-Supplemental reimbursement allowed after a reconsideration of services.
   - 724-No additional payment after a reconsideration for services.
   - 763-Paid per ASC FG at 235% implants not applicable or separate reimbursement (w/signed cert) not required Rule 134.402(G).
   - CAC-W3-In accordance with TCI-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 his claim was processed properly.

Issues

1. Under what authority is this request for medical fee dispute resolution considered?
2. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307?
3. What are the services in dispute?
4. What is the applicable fee guideline for the disputed services?
5. Is the respondent's denial of payment for CPT code 29826-LT supported?
6. Is the respondent's denial of payment for CPT code 76942-TC supported?
7. Is the respondent's denial of payment for CPT code 64415-59-TC supported?
8. Is the respondent's denial of payment for HCPCS code C1713 and L8699 supported?
9. Is the requestor entitled to additional reimbursement for ASC services, CPT code 29827-LT, 29823-LT, 29824-LT, 23430-LT and 20610-59-LT, rendered on June 21, 2017?

Findings

1. The requestor provided ASC services in the state of Virginia on June 21, 2017 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code§133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.

2. 28 Texas Administrative Code §133.307(c)(2)(F)-(I) states, "Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2)Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (F) the treatment or service code(s) in dispute; (G) the amount billed by the health care provider for the treatment(s) or service(s) in dispute; (H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute; and (I) the disputed amount for each treatment or service in dispute; (I) the disputed amount for each treatment or service in dispute"

   A review of the Table of Disputed Services finds the requestor did not comply with 28 Texas Administrative Code §133.307(c)(2)(F) - (I) because:
   - Under the column titled Treatment or Service Codes in Dispute the requestor wrote "All." The requestor did not list the treatment or service code.
   - Under the column titled Amount Billed the requestor wrote "37831.70." The requestor did not list the amount billed for each treatment or service code.
   - Under the column titled Amount Paid the requestor wrote "12012.85." The requestor did not list the amount paid for each treatment or service code.
   - Under the column titled Amount in Dispute the requestor wrote 25818.85." The requestor did not list the amount in dispute for each treatment or service code.

   Based upon this non-compliance for completing Table of Disputed Services in accordance with 28 Texas Administrative Code §133.307(c)(2)(F)-(I), the division will review all of the services billed on June 21, 2017.

3. On the disputed date of service the requestor billed $37,831.70 for CPT codes 29827-LT, 29823-LT, 29826-LT, 29824-LT, 23430-LT, 20610-LT-59, 66415-LT-59, 76942-TC, C1713 and L8699. The respondent paid $12,012.85. Per the Table of Disputed Services, the requestor is seeking additional reimbursement of $25,818.

4. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.

5. The respondent denied reimbursement for CPT code 29826-LT based upon reason "CAC-P12-Workers' compensation jurisdictional fee schedule adjustment;" and "662-Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package."

   28 Texas Administrative Code §134.402(b) (6) states, "Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   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, including the following paragraphs."

CPT code 29826 is described as “Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure).” The requestor appended modifier “LT-Left Side” to code 29826.

Per Medicare policy code 29826 may be reported with codes 29806-29825, 29827 or 29828. The requestor complied with Medicare policy because reported code 29826 with codes 29823, 29824 and 29827.

Per Medicare fee schedule, code 29826 has a payment indicator “N1.” Per Addendum DD1, “N1” is defined as “Packaged service/item; no separate payment made.”

The division finds the respondent’s denial of payment for code 29826 is supported. As a result, reimbursement is not recommended.

6. The respondent denied reimbursement for CPT code 76942-TC based upon reason “CAC-P12-Workers’ compensation jurisdictional fee schedule adjustment;” and “662-Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package.”

   CPT code 76942 is described as “Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation.” The requestor appended modifier “TC-Technical Component” to code 76942.

   Per Addendum BB, code 76942 has a payment indicator “N1.” Per Addendum DD1, “N1” is defined as “Packaged service/item; no separate payment made.”

   The division finds the respondent’s denial of payment for code 76942 is supported. As a result, reimbursement is not recommended.

7. The respondent denied reimbursement for CPT code 64415-59-TC based upon reason “CAC-236-This billing code is not compatible with another billing code provided on the same day according to NCCI or workers compensation state regulations/fee schedule requirements;” and “435-Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.”

   CPT code 64415 is described as “Injection, anesthetic agent; brachial plexus, single.” The requestor appended modifier “59-Distinct Separate Service” and “LT-Left Side.”

   Per CCI edits, CPT code 64415 has a conflict with codes 29823, 29824, 29826, 29827, 23430 and a modifier is not allowed to override the CCI conflict.

   The division finds the respondent’s denial of payment for code 64415-59-TC is supported. As a result, reimbursement is not recommended.

8. The respondent denied reimbursement for HCPCS codes C1713 and L8699 based upon reason, “CAC-97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated;” “CAC-P12- Workers’ compensation jurisdictional fee schedule adjustment;” “217-The value of this procedure is included in the value of another procedure performed on this date;” and “305-The implant is included in this billing and is reimbursed at the higher percentage calculation.”

   HCPCS code C1713 is defined as “Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable).”

   HCPCS code L8699 is defined as “Prosthetic implant, not otherwise specified.”

   28 Texas Administrative Code §133.10(f)(1)(W) states, “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 non-institutional medical bill related to Texas workers' compensation health care: (W) supplemental information (shaded portion of CMS-1500/field 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.” A review of the submitted medical bill finds the requestor did not indicate on fields 24d-24h a request for separate reimbursement for the implantables. Therefore, the requestor is not due separate reimbursement for codes C1713 and L8699.

9. To determine the appropriate reimbursement for the ASC services, CPT codes 29823-LT, 29824-LT, 29827-LT, 23430-LT, and 20610-LT-59, the division refers to 28 Texas Administrative Code §134.402(f)(1)(A).These codes are described as:

   - CPT Codes 29823 is described as "Arthroscopy, shoulder, surgical; debridement, extensive."
   - CPT code 29824 is described as "Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)."
   - CPT code 29827 is described as "Arthroscopy, shoulder, surgical; with rotator cuff repair."
   - CPT code 23430 is described as "Tenodesis of long tendon of biceps."
   - CPT code 20610 is described as "Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance."

   28 Texas Administrative Code §134.402(f)(1)(A) 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: ((A) The Medicare ASC facility reimbursement amount multiplied by 235 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 codes 29823-LT, 29824-LT, 29827-LT, 23430-LT, and 20610-LT-59 are non-device intensive procedures.

   The ASC Wage Index for Virginia is 0.7593.

   Code 29827-LT:

   Per Addendum AA, the Final CY 2017 Payment rate is $2,647.21

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

   This number multiplied by the ASC Wage Index = $1,005.00.

   Add these two together = $2,328.60.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $5,472.21.

   The respondent paid $5,915.75.

   Code 29823-LT:

   Per Addendum AA, the Final CY 2017 Payment rate is $1,217.75

   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $608.87

   This number multiplied by the ASC Wage Index = $462.31.

   Add these two together = $1,071.18.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,517.27.

   This code is subject to multiple procedure discounting; therefore, $2,517.27 X 50% = $1,258.63

   The respondent paid $1,360.67.

Code 29824-LT:

Per Addendum AA, the Final CY 2017 Payment rate is $1,217.75

To determine the geographically adjusted Medicare ASC reimbursement for code 29824:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = $608.87

This number multiplied by the ASC Wage Index = $462.31.

Add these two together = $1,071.18.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,517.27.

This code is subject to multiple procedure discounting; therefore, $2,517.27 X 50% = $1,258.63

The respondent paid $1,360.67.

Code 23430-LT:

Per Addendum AA, the Final CY 2017 Payment rate is $2,647.21

To determine the geographically adjusted Medicare ASC reimbursement for code 23430:

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

This number multiplied by the ASC Wage Index = $1,005.00.

Add these two together = $2,328.60.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $5,472.21.

This code is subject to multiple procedure discounting; therefore, $5,472.21 X 50% = $2,736.10.

The respondent paid $2,957.88.

Code 20610-59-LT:

Per Addendum AA, code 20610 has a payment indicator of "P3."
Per Addendum DD1 "P3" is defined as "Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2017 DWC conversion factor for this service is 57.5.

The Medicare Conversion Factor is 35.8887

Review of Box 32 on the CMS-1500 the services were rendered in zip code 23462 which is located in Virginia. Therefore, the Medicare participating amount will be based on the reimbursement for locality "Virginia".

The Medicare participating amount for 20610 is $46.93.

Using the above formula, the Division finds the MAR is $75.19.

This code is subject to multiple procedure discounting; therefore, $75.19 X 50% = $37.59

The respondent paid $32.44.

The appropriate reimbursement for the ASC services rendered on June 21, 2017 is $11,632.56. The respondent paid $12,012.85. As a result, additional reimbursement 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 entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/09/2018
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.