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
MISI ASC DALLAS, LLC

Respondent Name
TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-18-4549-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was initially denied on September 15, 2017 under denial code 15, 'The authorization number is missing, invalid, or does not apply to the billed services or provider.' We discovered that the physician had inadvertently documented a wrong diagnosis description on the operative report and sent it for correction. Once the doctor made the correction, we resubmitted the claim on March 6, 2018."

Amount in Dispute: $224,819.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent contends that Requestor's billing does not correlate with the operative procedure performed on August 1, 2017. Moreover, Requestor's billing does not match the preauthorized services identified on the notice from IMO dated June 14, 2017."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2017	Ambulatory Surgical Care Services CPT Code 62362	$162,115.63	$14,072.04
	Ambulatory Surgical Care Services CPT Code 62350	$22,803.50	$2,206.46
	HCPCS Code C1772	$36,750.00	$0.00
	HCPCS Code C1755	$3,150.00	$0.00
TOTAL		$224,819.13	$16,278.50

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, effective May 31, 2012 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 §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §133.10, effective April 1, 2014, sets out the healthcare provider billing procedures.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15-The authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 150-Payer deems the information submitted does not support this level of service.
   - Operative Report submitted diagnosis does not match billed charges.
   - Operative Report diagnosis does not match billed charges diagnosis or preauthorization diagnosis.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the applicable fee guideline for the disputed services?
2. Does a preauthorization issue exist?
3. Was the denial of payment due to invalid diagnosis supported?
4. Does the documentation support billed services?
5. Did the requestor request separate reimbursement for implantables?
6. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $224,819.13 for ambulatory surgical care services rendered to the injured worker on August 1, 2017. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.

2. The insurance carrier denied reimbursement for the disputed services, CPT codes 62362, 62350, C1772 and C1755, based upon "15-The authorization number is missing, invalid, or does not apply to the billed services or provider,"

   28 Texas Administrative Code §134.600(f) (1-3) states,

   > The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:
   >
   > (1) name of the injured employee;
   >
   > (2) specific health care listed in subsection (p) or (q) of this section;
   >
   > (3) number of specific health care treatments and the specific period requested to complete the treatments."

28 Texas Administrative Code §134.600(p)(2) requires preauthorization for "(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

Per 28 Texas Administrative Code §134.600(f)(2) the disputed services required preauthorization because ambulatory surgical care services are a specific health care listed in subsection (P)(2).

On June 14, 2017, the respondent's representative, Injury Management Organization (IMO), gave preauthorization approval for procedure codes "62350, 62362, 77003, 00670 and 62370" to be performed at MISI.

The division finds the respondent's denial of payment is not supported because requestor obtained preauthorization for ambulatory surgical care services for procedure codes 62362 and 62350.

3. The insurance carrier also denied reimbursement for the disputed services based upon "Operative Report submitted diagnosis does not match billed charges," and "Operative Report diagnosis does not match billed charges diagnosis or preauthorization diagnosis."

   The respondent wrote, "Respondent contends that Requestor's billing does not correlate with the operative procedure performed on August 1, 2017. Moreover, Requestor's billing does not match the preauthorized services identified on the notice from IMO dated June 14, 2017."

   28 Texas Administrative Code §134.600(d) states,

   > The insurance carrier is not liable under subsection (c)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury."

   The June 14, 2017 report from IMO lists ICD-10 diagnosis code "[redacted]-Complex regional pain syndrome I of unspecified lower limb."

   The original claim and corrected claim lists ICD-10 diagnosis code "[redacted]5[redacted]-Pain in left ankle and joints of left foot," and "[redacted]-Causalgia of left lower limb." The requestor wrote, "We discovered that the physician had inadvertently documented a wrong diagnosis description on the operative report and sent it for correction. Once the doctor made the correction, we resubmitted the claim on March 6, 2018." The Operative Report lists diagnosis as "Complex regional pain syndrome (neuropathic pain of the left foot and ankle), and Intractable left foot and ankle pain, status post work injury."

   The division finds per 28 Texas Administrative Code §134.600(d) the respondent is liable for preauthorized services unless a final adjudication had been made that this diagnosis was not compensable. The respondent did not support that the disputed treatment was not for the compensable injury; therefore, the denial of payment based upon the diagnosis not matching is not supported.

4. Per the submitted explanation of benefits, the insurance carrier also denied payment for the disputed services based upon "150-Payer deems the information submitted does not support this level of service."

   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.

The disputed services are defined as:

- CPT code 62362 is defined as "Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming."
- CPT code 62350 is defined as "Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy."
- HCPCS code C1772 is defined as "Infusion pump, programmable (implantable)."
- HCPCS code C1755 is defined as "Catheter, intraspinal."

The division reviewed the Operative Report that documents procedures performed as:

- Implantation of an InDura intrathecal catheter under fluoroscopy.
- Connection 2 and implantation of SynchroMed 2 infusion pump.
- Filling program analysis of SynchroMed pump.

The division finds the documentation supports billed service; therefore, the respondent's denial based upon reason "150" is not supported.

5. The requestor is seeking dispute resolution for HCPCS codes C1772 and C1755. The requestor noted on the bill in box 19 "Claim Separate reimbursement for implantables not requested. Corrected claim."

   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. The requestor indicated in box 19 that they were not seeking separate reimbursement for the implantables. The division finds the requestor is not due reimbursement for codes C1772 and C1755.

6. To determine the appropriate reimbursement for CPT codes 62362 and 62350 the division refers to28 Texas Administrative Code §134.402(f).

   A. Per ADDENDUM AA, CPT codes 62362 is a device intensive procedure.

      28 Texas Administrative Code §134.402(f)(2)(A)(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: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

      The following formula was used to calculate the MAR:

      - Step 1 calculating the device portion of the procedure:

The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 62362 for CY 2017 = $15,622.57.

This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 76.36% = $11,929.39.

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 62362 is $12,908.95.
  Per the Medicare fully implemented ASC reimbursement rate of $12,908.95 is divided by 2 = $6,454.47.
  This number multiplied by the City Wage Index for Dallas, TX $6,454.47 X 0.9895 = $6,386.69.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$12,841.16.
  The service portion is found by taking the geographically adjusted rate of $12,841.136 minus the device portion of $11,929.39 = $911.77.

  Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $911.77 X 235% = $2,142.65.

  The MAR is determined by adding the sum of the reimbursement for the device portion of $11,929.39 + the service portion of $2,142.65 = $14,072.04. The insurance carrier paid $0.00. As a result, the difference between the MAR and amount paid of $14,072.04 is recommended.

B. Per ADDENDUM AA, CPT code 62350 is a non-device intensive procedure.

28 Texas Administrative Code §134.402(f)(1)(B) 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.

The following formula was used to calculate the MAR:

The Medicare fully implemented ASC reimbursement for code 62350 CY 2017 is $1,887.76.

The Medicare fully implemented ASC reimbursement rate of $1,887.76 is divided by 2 = $943.88.

This number multiplied by the City Wage Index for Dallas, Texas is $943.88 X 0.9895 = $933.96.

Add these two together = $1,877.84.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $4,412.92. This code is subject to multiple procedure rule discounting of 50% = $2,206.46. The respondent paid $0.00. The requestor is due the difference between MAR and paid of $2,206.46.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $16,278.50.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $16,278.50, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		02/07/2019
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 Rule §133.307, effective May 31, 2012, *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. **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.