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
JEFFERSON AMBULATORY SURGERY CENTER

Respondent Name
AMERICAN CASUALTY CO OF READING PA

MFDR Tracking Number
M4-19-0144-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
SEPTEMBER 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Please find enclosed the completed Medical Fee Dispute Resolution Request and all medicals relating thereto along with the EOBs that were sent to my client. Please see my demand letter to CNA Insurance and my client's appeal letter to CAN Insurance which outlines why this matter was underpaid."

Amount in Dispute: $8,650.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier asserts that it has appropriately paid the Provider in accord with the Texas Fee Schedule for a Device Intensive Procedure with Separate Reimbursement for Implant. IN fact, it the Carrier's position that the Provider has been overpaid for these services."

Response Submitted by: Law Offices of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2017	Ambulatory Surgical Care (ASCs) Services CPT Code 22551	$6,729.28	$0.00
	ASCs Services CPT Code 22845	$0.00	$0.00
	HCPCS Code L8699	$1,920.38	$0.00
	ASCs Services Code 20931	$0.00	$0.00
TOTAL		$8,650.16	$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, 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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - P300-The amount paid reflects fee schedule reduction.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - 18-Exact duplicate claim/service.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Is the requestor entitled to additional reimbursement for ASC services rendered on November 14, 2017?

Findings

1. The requestor provided ASC services to an injured employee with an existing Texas Workers' Compensation claim in the state of Louisiana. The requestor was not satisfied 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 dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules
2. The fee guideline for ASC services is found at 28 Texas Administrative Code §134.402.
3. 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."
4. 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."
5. CPT code 22551 is described as "Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2."
6. Per ADDENDUM AA, CPT code 22551 is a device intensive procedure.
7. The requestor requested separate reimbursement for the implantables; therefore, Division rule at 28 TAC §134.402(f)(2)(B)(i)(ii) applies to this dispute.

   Division rule at 28 TAC §134.402(f)(2)(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: (2) Reimbursement for device intensive procedures shall be: (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the 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 ASC service portion multiplied by 235 percent."

8. Division rule at 28 TAC §134.402(f)(2)(B)(i)(ii) reimbursement for device intensive procedure code 22551 is a two step process:

   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 22551 for CY 2017 = $9,561.23.

   This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 47.15 % = $4,508.11.

   Step 2 calculating the service portion of the procedure:

   Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 22551 is $7,008.82.
   Per the Medicare fully implemented ASC reimbursement rate of $7,008.82 is divided by 2 = $3,504.41.
   This number multiplied by the City Wage Index for Louisiana 0.705 = $.2,470.60.
   The sum of these two is the geographically adjusted Medicare ASC reimbursement =$5,975.01.
   The service portion is found by taking the national adjusted rate of $5,975.01 minus the device portion of $4,508.11 = $1,466.90.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,466.90 X 235% = $3,447.21.

   Because separate reimbursement for implantables was requested the MAR for code 22551 is $3,447.21.

9. The requestor is also seeking additional reimbursement for HCPCS code L8699.

   HCPCS code L8699 is described as "Prosthetic implant, not otherwise specified."

10. To determine the appropriate reimbursement for HCPCS code L8699, the division refers to Division rule at 28 TAC §134.402(f)(2)(B)(i). The requestor submitted an invoice report for a cost of $3,600.00. Based upon the referenced statute, $3,600.00 + 10% = $3,960.00.

11. The division finds the MAR for ASC services rendered on November 14, 2017 is $7,407.21. The respondent paid $10,709.90. 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

Signature	Medical Fee Dispute Resolution Officer	11/20/2018 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.