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
ORCHID MEDICAL

Respondent Name
TPCIGA FOR AMERICAN MOTORISTS

MFDR Tracking Number
M4-19-0494-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
OCTOBER 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Covenant High Plains Surgery Center, LLC requested our company Orchid Medical bill for the surgical implants used in claimant's surgery on 12/11/2017. Orchid Medical received verbal authorization from Texas Property & Casualty Insurance adjuster Keith Squire to send a separate bill for the implants. We billed the surgical implants according to the TX fee schedule."

Amount in Dispute: $9,870.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TPCIGA supports the position statement provided by our medical review vendor Review Med, please see attached."

Review Med: "During our original review of the services in dispute, the Leads/Leads Cable were denied as inclusive of the allowance for the unit. These services are generally part of the unit; therefore, separate reimbursement is not warranted. The information submitted with the Medical Dispute does not support separate reimbursement. The two accessory items are not covered under the guidelines for implantables. Also, information was not submitted that supports these items being separate from the allowance for the unit."

Response Submitted By: Texas Property & Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2017	Ambulatory Surgical Care for HCPCS Code L8699	$242.00	$9,870.00
	Ambulatory Surgical Care for HCPCS Code L8699	$0.00	
	Ambulatory Surgical Care for HCPCS Code L8681	$1,787.50	

	Ambulatory Surgical Care for HCPCS Code L8699	$1,793.00	
	Ambulatory Surgical Care for HCPCS Code L8680	$7,073.00	
	Ambulatory Surgical Care for HCPCS Code L8687	$0.00	
TOTAL		$9,870.00	$9,870.00

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. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 193-Oriignal payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for the implantables?

Findings

The respondent paid $34,,970.00 for HCPCS code L8687 and L8699 rendered on December 11, 2017. The requestor is seeking additional reimbursement of $9,870.00 for HCPCS codes L8699, L8681 and L8680. The respondent denied reimbursement based upon reason code "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

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 requestor billed the following codes on the disputed date of service:

- L8680-Implantable neurostimulator electrode, each.
- L8699-Prosthetic implant, not otherwise specified.
- L8687-Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension.
- L8681-Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only.

28 Texas Administrative Code §134.402(b)(5) states "Implantable" means an object or device that is surgically:
(A) implanted,
(B) embedded,
(C) inserted,
(D) or otherwise applied, and
(E) related equipment necessary to operate, program, and recharge the implantable."

The requestor supported that the disputed implantables were purchased for claimant and were separate from code L8687. The division finds the respondent's denial of payment is not supported.

28 Texas Administrative Code §134.402(f)(2)(B)(i) states, "The reimbursement calculation used for establishing the MAR 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."

The Division reviewed the invoices and finds the total cost for the implantables is $42,840.00. The MAR for the implantables per 28 Texas Administrative Code §134.402(f)(2)(B)(i) is $44,840.00. The respondent paid $34,970.00. The difference between the MAR and paid is $9,870.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $9,870.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,870.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/13/2018
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.