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
PACIFIC EMPLOYERS INSURANCE CO

MFDR Tracking Number
M4-19-0554-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
OCTOBER 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Orchid Medical will send a separate bill for the **implant portion** only. The facility and doctor will submit their own bill for all other services rendered."

Amount in Dispute: $19,462.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billing provider, Orchid Medical, has not provided a correct certification for the cost of implants…The billing provider did not bill item IPG 7.5AH SCS under the correct HCPCS code. It was billed under code L8699 but should have been billed under code L8686…The billing provider is seeking reimbursement for the Cable billed under HCPCS Code L8699. This item was not implanted per the facility's implant log."

Response Submitted By: ForeSight

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2018	Ambulatory Surgical Care for HCPCS Code L8699	$2,211.09	$19,462.00
	Ambulatory Surgical Care for HCPCS Code L8699	$16,539.85	
	Ambulatory Surgical Care for HCPCS Code L8699	$242.00	
	Ambulatory Surgical Care for HCPCS Code L8681	$469.06	
TOTAL		$19,462.00	$19,462.00

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:
   - Charges for surgical implants will be reviewed separately by ForeSIGHT Medical.
   - 10-Upon review of submitted request for reconsideration. Fore Sight has determined that no additional allowance will be made.
   - 2-Device payment was based on documentation provided by your facility.
   - 4-This item was determined to be a supply/non-implantable item.
   - 131-Claim specific/negotiated discount.
   - 18-Duplicate claim/service.

Issues

Is the requestor entitled to additional reimbursement for the implantables?

Findings

The requestor billed $42,687.50 for implantables billed with HCPCS codes L8699 (X3) and L8681. The respondent paid $23,225.50. The requestor is seeking additional reimbursement of $19,462.00.

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:

- L8699-Prosthetic implant, not otherwise specified.
- L8681-Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only.

According to the explanation of benefits and respondent's position summary, HCPCS code L8699 at $242.00 was denied based upon reason adjustment code "4-This item was determined to be a supply/non-implantable item."

To determine if the denial was appropriate, the division refers to 28 Texas Administrative Code §134.402(b)(5).

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 implantable billed with code L8699- Multilead Cable meets definition of Implantable per 28 Texas Administrative Code §134.402(b)(5)(E) . 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 $40,860.00. The MAR for the implantables per 28 Texas Administrative Code §134.402(f)(2)(B)(i) is $42,860.00. The respondent paid $23,225.50. The difference between the MAR and paid is $19,634.50. The requestor is seeking a lesser amount of $19,462.00; this amount is recommended for additional reimbursement.

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 $19,462.00.

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 $19,462.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/20/2018
Signature	Medical Fee Dispute Resolution Officer	Date
		11/20/2018
Signature	Director of Medical Fee Dispute Resolution	Date

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.