TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MVP SPECIALIST SURGERY CENTER

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-3032-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the data provided and have this claim reprocessed to allow for proper payment."

Amount in Dispute: $62,554.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that an overpayment of $8,946.00 has been made…This was determined because the bill was processed at the surgeon rates instead of ASC rates in error for procedure codes."

Response Submitted By: Broadpsire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2018	CPT Code 22612 Ambulatory Surgical Care Services	($1,748.34)	$0.00
	CPT Code 22558 Ambulatory Surgical Care Services	$27,253.30	$0.00
	CPT Code 63042 Ambulatory Surgical Care Services	$3,158.03	$0.00
	CPT Code 22830 Ambulatory Surgical Care Services	$5,729.35	$0.00

May 4, 2018	CPT Code 22840 Ambulatory Surgical Care Services	$9,329.24	$0.00
	CPT Code 22853 Ambulatory Surgical Care Services	$6,234.17	$0.00
	CPT Code 61783 Ambulatory Surgical Care Services	$5,578.64	$0.00
	CPT Code 20937 Ambulatory Surgical Care Services	$5,328.56	$0.00
	CPT Code 20930 Ambulatory Surgical Care Services	$5,320.35	$0.00
TOTAL		$62,554.89	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - 522-The reimbursement for the implantable is reimbursed at the separate carve our percentage calculation.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 59-Processed based on multiple or concurrent procedure rules.
   - 662-Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package.
   - W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issue

Is the requestor entitled to additional reimbursement for ASC services rendered on May 4, 2018?

Findings

1. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
2. 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."
3. On the disputed date of service, the requestor billed CPT codes 22612-SG, 22558-SG, 63042-SG, 22830-SG-59, 22840-SG, 22853-SG, 61783-SG-59, 20937-SG, 20930-SG, L8699 and A4649. Only CPT codes 22612-SG, 22558-SG, 63042-SG, 22830-SG-59, 22840-SG, 22853-SG, 61783-SG-59, 20937-SG, 20930-SG are in dispute.

4. The disputes services are described as:

   - CPT code 22612 is described as "Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)."
   - CPT code 22558 is described as "Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar."
   - CPT code 63042 is described as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar ."
   - CPT code 22830 is described as " Exploration of spinal fusion."
   - CPT code 22840 is described as "Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)."
   - CPT code 22853 is described as "Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)."
   - CPT code 61783 is described as "Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)."
   - CPT code 20937 is described as "Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)."
   - CPT code 20930 is described as "Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)."

5. The respondent wrote, "It is our position that an overpayment of $8,946.00 has been made…This was determined because the bill was processed at the surgeon rates instead of ASC rates in error for procedure codes."

   The division reviewed Medicare's reimbursement guidelines and finds:

   - Per Medicare's CCI guidelines, CPT code 22830 is unbundled from code 22558. The requestor appended modifier 59 to code 22830 to differentiate the service from code 22558.

     Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service."

     The requestor supported that code 22830 was performed at L4-5 and L5-S1 spinal levels, and code 22558 was performed at L3-4; therefore, the requestor is entitled to reimbursement per fee guideline.

   - Per Medicare's CCI guidelines, CPT code 61783 is unbundled from code 63042. The requestor appended modifier 59 to code 61783 to differentiate the service from code 63042.

     The requestor supported the use of a robotic surgical assistance system for harvesting of autograft bone through a separate incision; therefore, the requestor is entitled to reimbursement per fee guideline.

6. The division reviewed the billing and explanation of benefits, and finds the insurance carrier paid for the implantables separately. The applicable guideline for the disputed services is found at 28 Texas Administrative Code §134.402(f)(1)(B) that 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: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-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 Medicare ASC facility reimbursement amount multiplied by 153 percent."
7. Per Addendum AA, codes 20930, 20937, 61783, 22853, and 22840 have a payment indicator "N1." Per Addendum DD1, "N1" is defined as "Packaged service/item; no separate payment made." As a result, reimbursement is not recommended for these codes.
8. A review of Addendum AA, ASC Covered Surgical Procedures for CY 2018 finds that codes 22558 and 22830 are not listed. Therefore, 28 Texas Administrative Code §134.402(i) applies which states "If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:

   (1) The agreement may occur before, or during, preauthorization.

   (2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

   (3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:

   (A) the reimbursement amount;

   (B) any other provisions of the agreement; and

   (C) names, titles and signatures of both parties with dates.

   (4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1)."

   The requestor did not submit any documentation that an agreement was reached prior or during preauthorization. The dispute packet did not contain a signed copy of an agreement, that identified the parties to the agreement, or the amount of reimbursement as required by 28 Texas Administrative Code §134.402(i). As a result, reimbursement is not recommended for codes 22558 and 22830.
9. Per 28 Texas Administrative Code §134.402(f), the ASC services eligible for reimbursement are codes 22612 and 63042.

22612:

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 22612 CY 2018 is $5,069.05.

The Medicare ASC reimbursement rate is divided by 2 = $2,534.52.

This number multiplied by the City Wage Index for Houston, Texas is $2,534.52 X 0.9750 = $2,471.15.

Add these two together equals the geographically adjusted Medicare ASC reimbursement rate is $5,005.67.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of153% = $7,658.67.

63042:

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 63042 CY 2018 is $2,721.37.

The Medicare ASC reimbursement rate is divided by 2 = $1,360.68.

This number multiplied by the City Wage Index for Houston, Texas is $1,360.68 X 0.9750 = $1,326.66.

Add these two together equals the geographically adjusted Medicare ASC reimbursement rate is $2,687.34.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of153% = $4,111.63. This code is subject to multiple procedure rule discounting of 50% = $2,055.81.

The MAR for the ASC services is $9,714.48. The respondent paid $10,315.90. 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 services in dispute.

Authorized Signature

		04/04/2019
Signature	Medical Fee Dispute Resolution Officer	Date
		04/04/2019
Signature	Director of Medical Fee Dispute Resolution	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, 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 MDR 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.