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
SOUTH SHORE SURGICENTER

Respondent Name
ACADIA INSURANCE CO

MFDR Tracking Number
M4-20-0230-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 26, 2019

REQUESTOR'S POSITION SUMMARY

"According to the TDI guidelines if the indicator on the Medicare Fee Schedule is a J8 the carrier should allow this code at 235% of Medicare ASC fee schedule. This is not how Liberty Mutual allowed this code as well as not allowing for the reimbursement of the hardware used…CPT code 25609 2019 Medicare ASC Fee Schedule $3915.73. $3,915.73 X 235% = $9201.97…CPT code C1713 – As per guidelines we requested separate reimbursement for the carrier on the claim and attached the invoice to the claim when it was submitted. Invoice attached shows cost of the hardware is $2339.00."

Amount in Dispute: $5,914.93

RESPONDENT'S POSITION SUMMARY

"The provider is not entitled to any reimbursement beyond what has already ben paid which is $5,626.04."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2019	Ambulatory Surgical Care Services (ASCs) CPT Code 25609	$3,575.93	$63.82
	ASCs HCPCS Code C1713	$2,339.00	$0.00
TOTAL		$5,914.93	$63.82

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 (DWC).

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 §133.10, sets out the required health care provider billing procedures.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
   - 97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
   - 4915-The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - W3- Additional payment made on appeal/reconsideration.
   - U301-This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on June 6, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $5,914.93 for ASC services rendered to the injured worker on June 6, 2019. The insurance carrier paid $5,626.04 for the disputed services based upon the fee guideline.

2. The respondent denied reimbursement for HCPCS code C1713 based upon reasons, "97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated," and "4915-The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment."

   28 TAC §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."

   HCPCS code C1713 is described as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

   Based upon the review of the submitted documentation and above referenced statute, the DWC finds:

   - The requestor did not indicate on the medical bill on fields 24d-24h a request for separate reimbursement for the implantables as required by 28 Texas Administrative Code §133.10(f)(1)(W).
   - The requestor is not due separate reimbursement for HCPCS code C1713 due to billing errors.

3. The fee guidelines for disputed services is found in 28 TAC §134.402.

4. 28 TAC §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.

5. 28 TAC §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.

CPT code 25609 is described as " Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments."

6. To determine the appropriate reimbursement for CPT code 25609 the DWC refers to 28 TAC §134.402(f).

   28 TAC §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."

   Per ADDENDUM AA, CPT codes 25609 is a device intensive procedure.

   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 25609 for CY 2019 = $5,699.59

     The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25609 for CY 2019 is 44.52%

     Multiply these two = $2,537.46

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 25609 for CY 2019 is $3,915.73.

     This number is divided by 2 = $1,957.86.

     This number multiplied by the City Wage Index for League City, TX of 0.9812= $1,921.05.

     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,878.91.

     The service portion is found by taking the geographically adjusted rate of minus the device portion = $1,341.45.

     Multiply the service portion by DWC payment adjustment of 235% = $3,152.40.

   - Step 3 the MAR is determined by adding the sum of the reimbursement for the device portion + the service portion = $5,689.86. The insurance carrier paid $5,626.04. As a result, additional reimbursement of $63.82 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $63.82.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $63.82, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		10/18/2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.