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
GRAPEVINE SURGICARE

Respondent Name
UTICA NATIONAL NSURANCE CO OF TEXAS

MFDR Tracking Number
M4-20-2770-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 24, 2020

REQUESTOR'S POSITION SUMMARY

"At this time we are requesting that this claim paid in accordance with the 2020 Texas Workers Compensation Fee Schedule and Guidelines."

Email dated September 2, 2020: "We received payments from the carrier 06/01/20 & 07/06/20. The claim is still underpaid according to the fee schedule. Please continue with the MFDR process."

Amount in Dispute: $5,745.21

RESPONDENT'S POSITION SUMMARY

"L8699 total charge $7,110.00 was priced by Foresight/Paradigm and they have submitted the response for this code separately."

Response Submitted By: Genex

"Our database of manufacturer pricing shows the handwritten costs to be standard list costs. The provider did not submit an invoice showing cost minus any discounts or rebates received for the items per regulation or 'net invoice cost'…It is therefore impossible to tell the true invoice cost of the implants to the provider with the documents submitted….total recommended allowance is the true invoice cost of $5,332.50 plus10% ($533.25) for a total reimbursement amount of $5,865.73."

Response Submitted By: Foresight

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 64910	$0.00	$0.00
	ASC Services for CPT Code 25260	$0.00	$0.00

	ASC Services for HCPCS Codes L8699	$5,745.21	$0.00
TOTAL		$5,745.21	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 TAC §133.10, sets out the required health care provider billing procedures.
4. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - 192-Non-stndard adjustment code from paper remittance advice.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor due additional reimbursement for HCPCS code L8699 rendered on March 31, 2020?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $5,745.21 for HCPCS code L8699 rendered on March 31, 2020. On the disputed date, the requestor also billed CPT codes 64910 and 25260 that are not in dispute.

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

The fee guideline for ASC services is found at 28 TAC §134.402.

Per Addendum AA, CPT code 64910 is a device intensive procedure. The requestor sought separate reimbursement for the implantables; therefore, 28 TAC §134.402(f)(2)(B)(i)(ii) applies to this dispute.

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.

28 TAC §134.402(g)(1)(B) states,

> A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable. (1) The facility or surgical implant provider requesting reimbursement for the implantable shall: (B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled.

The DWC reviewed the submitted documentation and finds:

- The respondent wrote, "total recommended allowance is the true invoice cost of $5,332.50 plus10% ($533.25) for a total reimbursement amount of $5,865.73." The respondent's total recommended reimbursement amount is greater than the disputed amount.
- The requestor contends that the claim is still underpaid.
- The requestor did not submit an invoice to support the cost of the implantables.
- The requestor did not submit "a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable."
- The respondent's denial of payment is supported because the documentation does not support the disputed amount is in accordance with the fee guideline.

Conclusion

For the reasons stated above, the DWC 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

		09/23/2020
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 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 with the DWC. **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.