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
THE CENTER FOR SPECIAL SURGERY

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-21-0681-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
DECEMBER 17, 2020

REQUESTOR'S POSITION SUMMARY

"AIG has not processed our claim for services rendered as indicated by Texas Workers' Compensation fee schedule. We have appealed this claim twice with AIG maintaining their original decision."

Amount in Dispute: $1,966.32

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 25608	$1,521.99	$271.11
	ASC Services for CPT Code 64417	$444.33	
	ASC Services for HCPCS Code C1713	$0.00	$0.00
TOTAL		$1,966.32	$271.11

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 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment codes:
   - Workers' compensation jurisdictional fee schedule adjustment.
   - Charge for this procedure exceeds the amount indicated in the schedule allowance.
   - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - Your billing has been reviewed using the National Correct Coding Initiative, (NCCI) edits. A procedure code has been billed which is not allowed separate reimbursement when performed in addition to another procedure or other procedures billed on this date. This typically applied due to misuse of modifier -59 as it applied to procedures (PTP) edits. Additional specific reasons for non-payment may also include non-compliance with CPT coding guidelines or CMS manual coding practices, the presence of a mutually exclusive procedure, or a procedure which the disallowed code is consolidated into.
   - Anesthesia fees are not payable when local infiltration, digital or regional block, or topical anesthesia is administered by the operating surgeon or assistant. Such services are included in the value of the surgical procedure.
   - This bill has been re-reviewed per your request. Our review is complete and our decision remains the same.
   - No additional reimbursement allowed after review of appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on April 24, 2020?

Findings

1. The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson received notice of this medical fee dispute on December 22, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution in the amount of $1,966.32 for ASC services rendered on April 24, 2020.

3. The respondent paid $5,386.44 for the ASC services based upon the fee guideline.

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

   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.

   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.

5. The respondent denied reimbursement for CPT code 64417 based upon the allowance/benefit of this code is bundled to code 25608. The requestor appended the "XP" modifier to code 64417. The XP modifier was applied when a service is distinct because it was performed by a different practitioner.

The 2020 National Correct Coding Initiatives Manual, Chapter 2, section (B)(4), states in part,

> Under certain circumstances, an anesthesia practitioner may separately report an epidural or peripheral nerve block injection (bolus, intermittent bolus, or continuous infusion) for postoperative pain management when the surgeon requests assistance with postoperative pain management. ..A peripheral nerve block injection (CPT codes 64XXX)for postoperative pain management may be reported separately with an anesthesia 0XXXX code only if the mode of intraoperative anesthesia is general anesthesia, subarachnoid injection, or epidural injection, and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block injection…An epidural or peripheral nerve block injection (62320-62327 or 64450-64530 as identified above) for postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or regional anesthesia by epidural injection as described above may be administered preoperatively, intraoperatively, or postoperatively.

Based upon the submitted Operative Report, the claimant underwent general anesthesia for CPT code 25608, and then a peripheral nerve block for postoperative pain management by an anesthesiologist; therefore, the respondent's denial based upon unbundling is not supported.

6. To determine the appropriate reimbursement for CPT code 25608 and 64417 the DWC refers to 28 TAC §134.402(f). The requestor did not seek separate reimbursement for the implantables; therefore, no reimbursement for HCPCS code C1713.

   A. Per ADDENDUM AA, CPT codes 25608 is a device intensive procedure.

   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."

   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 25608 for CY 2020 = $5,981.95.

     The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25608 for CY 2020 is 43.25%

     Multiply these two = $2,587.19

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare ASC reimbursement rate for code 25608 for CY 2020 is $4,019.81.
     This number is divided by 2 = $2,009.90.
     This number multiplied by the City Wage Index for San Antonio, Texas of 0.8432 = $1,694.75.
     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,704.65.
     The service portion is found by taking the geographically adjusted rate minus the device portion = $1,117.46.

     Multiply the service portion by the DWC payment adjustment of 235% = $2,626.04.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $5,213.22.

The DWC finds the MAR for CPT code 25608 is $5,213.22.

B. Per ADDENDUM AA, CPT code 64417 is a non-device intensive procedure.

28 TAC §134.402(f)(1)(A) states in part,

> The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 64417 CY 2020 is $410.32.

The Medicare ASC reimbursement is divided by 2 = $205.16.

This number multiplied by the City Wage Index for San Antonio, Texas of 0.8432= $172.99.

Add these two together = $378.15.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $888.65. This code is subject to multiple procedure rule discounting of 50% = $444.33.

The DWC finds the MAR for CPT code 64417 is $444.33.

The DWC finds the MAR for the ASC services rendered on April 24, 2020 is $5,657.55. The respondent paid $5,386.44. The DWC finds the requestor is due additional reimbursement of $271.11.

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 $271.11.

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 $271.11, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/24/2021 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.