TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Complete Surgery
Houston North

Respondent Name
TPCIGA for Colonial Casualty Insurance Co

MFDR Tracking Number
M4-23-2991-01

Carrier's Austin Representative
Box Number 50

DWC Date Received
July 25, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 8, 2022	62362	$16,874.73	$0.00
November 8, 2022	62350	$1,570.75	$0.00
November 8, 2022	62368	$43.84	$0.00
November 8, 2022	77003	$0.00	$0.00
November 8, 2022	E0783	$0.00	$0.00
November 8, 2022	00670	$0.00	$0.00
	Total	$18,489.32	$0.00

Requestor's Position

"CSHN billed and should have been paid as indicated below. The claim was not paid according to the BCBS provider contract/fee schedule."
Amount in Dispute: $18,489.32

Respondent's Position

"TPCIGA supports the position statement provided by our medical review vendor Review Med, please see attached.
Response submitted by: Texas Property & Casualty Insurance Guaranty Associated

"We have reviewed the submitted request and determined no additional allowance is due."
Response submitted by: ReviewMed

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC 134.402 sets out the fee guidelines for ambulatory surgical services.

Denial Reasons

The insurance carrier reduced and packaged the payment for the disputed services with the following claim adjustment codes:

- 4123 – Allowance is based on Texas ASC Device Intensive procedure calculation and guidelines.
- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 851 – The allowance was adjusted in accordance with multiple procedure rules and/or guidelines.
- 903 – In accordance with Clinical based Coding edits (NATIONAL CORRECT CODING INITIATIVE/OUTPATIENT CODE EDITOR), Component code of comprehensive surgery procedure 60000-69999) has been disallow.
- 97 – Payment adjusted because 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 code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 985 – Service is not allowable under Medicare's ASC guidelines.
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

Issues

1. Is the insurance carrier's reductions supported?

2. What rule(s) are applicable to reimbursement?

3. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for the following codes.

   - 62362 - Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming. ASC Payment Indicator J8, Device-intensive procedure, Multiple Procedure Reduction Guidelines apply.

   - 62350 – Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump, without laminectomy. ASC Payment Indicator J8 – Device-intensive procedure, Multiple Procedure Reduction Guidelines apply.

   - 62368 – Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming. ASC Payment Indicator – P3.

   The insurance carrier reduced the allowed amounts for codes 62362 and 62350 based on workers' compensation fee schedule. Code 62368 was denied based on NCCI edits.

   DWC Rule §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…"

   Review of the applicable NCCI edits found procedure code 62368 has an unbundle relationship with code 62362. The insurance carrier's denial is supported.

   The remaining codes in dispute will be calculated per the applicable fee guidelines to determine if the insurance carrier's reduction of payment based on workers compensation fee guideline is supported.

2. DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.

   DWC Rule 28 TAC §134.402 (f) states in pertinent part 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 for device intensive procedures shall be the sum of the ASC device portion and the ASC service portion multiplied by 235 percent.

The following formula was used to calculate the MAR:

Procedure Code 62362 has a payment indicator of J8. This is a device intensive procedure paid at an adjusted rate. 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 62362 is $17,405.31.
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 62362 for 2022 is 74.11%.
- Multiply these two ($17,405.31 x 74.11%) = $12,899.07

Step 2 calculating the **service portion** of the procedure:

- Per Addendum AA, the Medicare ASC reimbursement rate for code 62362 is $14,468.87.
- This number is divided by 2 ($14,468.87 ÷ 2) = $7,234.43.
- This number multiplied by the CBSA for Houston, Texas of 0.9925 ($7,234.43 x 0.9925) = $7,180.18.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement ($7,234.43 + $7,180.18) = $14,414.61.
- The service portion is found by taking the geographically adjusted rate minus the device portion = ($14,414.61 - $12,899.07) = $1,515.54
- Multiply the service portion by the DWC payment adjustment of 235% ($1,515.53 x 235%) = $3,561.52.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion ($12,899.07 + $3,561.52) =$16,460.59.

Procedure Code 62350 has a payment indicator of J8. This procedure is subject to multiple procedure discount. The MAR will be reduced by 50%. DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount 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 62350 = $5,823.95.
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 62350 is 48.22%.
- Multiply these two ($5,823.95 x 48.22%) = $2,808.31

Step 2 calculating the **service portion** of the procedure:

- Per Addendum AA, the Medicare ASC reimbursement rate for code 62350 is $3,613.14.
- This number is divided by 2 = $3,613.14 ÷ 2 = $1,806.57
- This number multiplied by the CBSA for Houston, Texas of 0.9925 = $1,806.57 x $0.9925 = $1,793.02.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement ($1,806.57 + $1,793.02) =$3,599.59.
- The service portion is found by taking the geographically adjusted rate minus the device portion ($3,599.59 - $2,808.31) = $791.28.
- Multiply the service portion by the DWC payment adjustment of 235% = ($791.28 x 235%) = $1,859.51.
- Step 3 calculating the MAR:
- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion divided by 50% ($2,808.31 + $1,859.41= $4,667.72 ÷ 50%) = $2,333.86.

3. The DWC finds the MAR for CPT code 62362 is $16,460.59. The respondent paid $16,460.59. No additional payment is recommended.

   Procedure code 62350 has a MAR of $2,333.86. The respondent paid $2,592.19. No additional payment is due.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 16, 2023
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.