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
STONEGATE SURGERY CENTER LP

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-16-1498-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim did not pay correctly. We billed 64708 an 26410 to allow at 153% of Medicare fee schedule, which means we are expecting reimbursement for the implant L8699 per TDI guidelines."

Amount in Dispute: $1,980.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor did not state it wanted separate payment for implants with the initial bill. . . . Texas Mutual paid the initial bill at the full 235% of Medicare for an ASC. . . . No payment was made for code L8699 as this is not an implantable but a biological, which exceeds ODG. As a biological it does not meet the definition of an implantable at (b)(5)(A-E) of Rule 134.402."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 27, 2015	Ambulatory Surgical Supply	$1,980.00	$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the fee guideline for ambulatory surgical center facility services.
3. 28 Texas Administrative Code §134.600 sets out the rules for preauthorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 784 – SERVICE EXCEEDS RECOMMENDATIONS OF TREATMENT GUIDELINES (ODG)
- 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE
- A09 – DWC RULE DEFINITION OF IMPLANTABLES DOES NOT ENCOMPASS BIOLOGICALS: BIOLOGICALS AREN'T PAID AS IMPLANTABLES PER CH 134 DWC RULE & MEDICARE
- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Is there a contracted fee arrangement applicable to the item in dispute?
2. Was preauthorization required?
3. Is the disputed item an "implantable" as defined by Division rules?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed implantable item with claim adjustment reason code 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT." Review of the submitted information finds no documentation to support a contracted fee arrangement applicable to the services in dispute. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The insurance carrier denied the disputed implantable item with claim adjustment reason codes 197 – "PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT."; 784 – "SERVICE EXCEEDS RECOMMENDATIONS OF TREATMENT GUIDELINES (ODG)"; and 786 – "DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT." As stated above, no documentation was presented to support a contract between the parties to this dispute.

   28 Texas Administrative Code §134.600(c)(1)(B) provides that, in the absence of an emergency, the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care only when preauthorization of any health care listed in §134.600(p) was approved prior to providing the health care. Rule §134.600(p)(2) states that non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

   The requestor presented documentation to support preauthorization of surgery to repair the abductor pollicis longus and radial nerve. The disputed item is a supply used in the surgical repair of the radial nerve. The insurance carrier's denial with respect to preauthorization is not supported.

3. The insurance carrier denied the disputed item with claim adjustment reason code A09 – "DWC RULE DEFINITION OF IMPLANTABLES DOES NOT ENCOMPASS BIOLOGICALS: BIOLOGICALS AREN'T PAID AS IMPLANTABLES PER CH 134 DWC RULE & MEDICARE." The respondent states, "No payment was made for code L8699 as this is not an implantable but a biological, which exceeds ODG. As a biological it does not meet the definition of an implantable at (b)(5)(A-E) of Rule 134.402."

   The Division's *Ambulatory Surgical Center Fee Guideline* at 28 Texas Administrative Code § 134.402(b)(5) defines "Implantable" as an object or device that is surgically:

   (A) implanted,
   (B) embedded,
   (C) inserted,

(D) or otherwise applied, and
(E) related equipment necessary to operate, program, and recharge the implantable.

The submitted invoice describes the item as "40.0mg Amnio Fix Injectable." The operative report states, "The radial nerve and tendon repair were made with reconstituted amniotic allograft, 40 mg." Review of the submitted information finds that the disputed supply was neither an object nor a device, but rather a quantity of fluid substance. As such, it does not meet the definition of an implantable as specified in Rule §134.402(b)(5). The disputed supply is therefore not eligible for separate reimbursement as an implantable.

4. Procedure code L8699 represents a "prosthetic implant, not otherwise specified." The respondent asserts, "this is not an implantable but a biological." Review of the submitted information finds that the documentation is not sufficient to support that the item corresponds to the description of code L8699; the requestor has not supported the item as billed.

   Regardless, this code is also not payable as billed. Under Medicare payment policy, payment for implantable prosthetic devices is included in the ASC payment for the covered surgical procedure. Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 14, §10.4, ASCs may not bill separately for implantable prosthetic devices without OPPS pass-through status. Procedure code L8699 does not have OPPS pass-through status (status indicator H); L8699 has a status indicator of N, denoting packaged codes with no separate payment. Payment for this item is included in the primary procedure(s) performed in that encounter. The insurance carrier previously paid for the other billed surgical procedures at the greater 235% ASC rule multiplier—a rate that is inclusive of implantables and packaged supplies. Consequently, additional payment cannot be 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 disputed services.

Authorized Signature

	Grayson Richardson	February 26, 2016
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 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 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 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.