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
MVP SPECIALIST SURGERY CENTER

Respondent Name
JEFFERSON COUNTY

MFDR Tracking Number
M4-19-3543-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
MARCH 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the data provided and have this claim reprocessed to allow for proper payment."

Amount in Dispute: $54,881.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The amount in dispute is $49,741.46. Respondent submits that its reason for denial/reduction of payment are supported and that no additional reimbursement is due to the Provider."

Response Submitted By: White Espey, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2018	Ambulatory Surgical Care Services	$54,881.49	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - IA-A copy of an invoice showing the cost of the implant, supplies, materials, device or durable medical equipment must be received. This invoice must be scientific to the patient, show cost of acquisition, and/or cost of the product or equipment.
   - 96-Non-covered charge(s).
   - 96-The procedure or service has not been assigned a fee schedule payment amount or the amount is zero.
   - 96-a procedure has been billed for which a payment is not allowed. The procedure is either not covered, not recognized as a valid service, or not routinely covered.
   - 16-The reduction was made for reasons indicated in note below or on the attached note or letter.
   - P14-Additional payment made on appeal/reconsideration.
   - 97-The benefit of this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - A4-The payment for this service is always bundled into payment of other service and not paid as a stand-alone charge.
   - APRV-Amount is approved.
   - NC-a procedure has been billed for which a payment is not allowed. The procedure is either not covered, not recognized as a valid service, or not routinely covered.
   - NOPA-Services are not authorized.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
   - The charge for this procedure exceeds the amount indicated in the fee schedule.
   - Payment of multiple surgery procedures rendered in an Ambulatory Surgery Center is limited to the following: 100 percent of the payment amount for the surgery in the highest ASC payment group each additional procedure is paid at 50 percent of the maximum payment for the ASC payment group.
   - FRST-Charges for surgical implants will be reviewed separately by ForeSight Medical.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issue

Is the requestor entitled to additional reimbursement for ASC services rendered on November 21, 2018?

Findings

1. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
2. 28 Texas Administrative Code §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."
3. On the disputed date of service, the requestor billed CPT codes 22633-SG, 63042-SG-59-RT, 63042-SG-59-LT, 61783-SG-59, 22840-SG, 22853-SG, 20937-SG, 20930-SG, L8699 (X4), and A4649.
4. The disputes services are described as:
   - CPT code 22633 is described as "Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar."
   - CPT code 63042 is described as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar ."

- CPT code 61783 is described as " Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)."
- CPT code 22840 is described as "Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)."
- CPT code 22853 is described as "Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)."
- CPT code 20937 is described as "Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)."
- CPT code 20930 is described as "Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)."
- HCPCS code L8699 is described as "Prosthetic implant, not otherwise specified."
- HCPCS code A4649 is described as "Surgical supply; miscellaneous."

5. The respondent wrote, "Respondent submits that its reason for denial/reduction of payment are supported and that no additional reimbursement is due to the Provider."

6. The division reviewed the billing and explanation of benefits, and finds the insurance carrier paid for the implantables separately. The applicable guideline for the disputed services is found at 28 Texas Administrative Code §134.402(f)(1)(B) that 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: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-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 Medicare ASC facility reimbursement amount multiplied by 153 percent."
7. Per Addendum AA, codes 20930, 20937, 61783, 22853, and 22840 have a payment indicator "N1." Per Addendum DD1, "N1" is defined as "Packaged service/item; no separate payment made." As a result, reimbursement is not recommended for these codes.
8. Per Medicare's reimbursement policy, HCPCS code A4649 is not billable by an ASC; therefore, reimbursement is not recommended.
9. Per 28 Texas Administrative Code §134.402(f), the ASC services eligible for reimbursement are codes 22633, 63042 (X2), and L8699 (X4).
10. The respondent wrote that initially payment was denied for code 26633; however, "Additional payment of $7,756.84 was made." A review of Addendum AA, ASC Covered Surgical Procedures for CY 2018 finds that code 22633 is not listed. Therefore, 28 Texas Administrative Code §134.402(i) applies which states "If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:

    (1) The agreement may occur before, or during, preauthorization.

(2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

(3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) any other provisions of the agreement; and

(C) names, titles and signatures of both parties with dates.

(4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1)."

The requestor did not submit any documentation that an agreement was reached prior or during preauthorization. The dispute packet did not contain a signed copy of an agreement, that identified the parties to the agreement, or the amount of reimbursement as required by 28 Texas Administrative Code §134.402(i). As a result, additional reimbursement is not recommended for code 22633.

11. The respondent wrote, "Payment was initially issued without implants which allows payment at a higher rate compared to allowance with implants. Since provider has requested payment on implants, the correct allowance is $2,055.83. Bill has been adjusted to pay the correct amount.

    63042:

    The following formula was used to calculate the MAR:

    The Medicare ASC reimbursement for code 63042 CY 2018 is $2,721.37.

    The Medicare ASC reimbursement rate is divided by 2 = $1,360.68.

    This number multiplied by the City Wage Index for Houston, Texas is $1,360.68 X 0.9750 = $1,326.66.

    Add these two together equals the geographically adjusted Medicare ASC reimbursement rate is $2,687.34.

    To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $4,111.63.

    The requestor billed for two units. Code 63042 is subject to multiple procedure rule discounting of 50% = $2,055.81. The MAR for both units is $6,167.44. The respondent paid $9,472.94. As a result, additional reimbursement is not recommended.

12. On the disputed date of service, the requestor billed for the implantables with HCPCS codes L8699 and A4649. The division reviewed the submitted documentation and finds:

Code	Description	MAR	IC Paid
L8699	50 Cross Connector	$1,150.00 X 10% = $1,265.00	$1,265.00
L8699	Screw and Rod 55565-45 and R5510-045	Invoice does not list cost	$7,150.00
L8699	Ostegro 2cc Allograft	$556.50 X 10% = $612.15	$612.15
L8699	Interbody Cage	$6,500.00 X 10% = $7,150.00	$2,750.00

Total		$9,027.15	$11,777.15

The MAR for the ASC services is $22,951.43. The respondent paid $23,645.69. As a result, additional reimbursement is not 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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	05/08/2019 Date
Signature	Director of Medical Fee Dispute Resolution	05/08/2019 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, 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 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 MDR 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.