Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WILLIAM D STRINDEN MD
116 CHRISTIE DRIVE
LUFKIN TX 75904

Respondent Name
DEEP EAST TEXAS SELF INSURANCE O

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-12-3063-01

MFDR Date Received
JUNE 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 99070 Initial emergency repair of tendon was performed in our accredited office based surgery facility. ..Insurer refused to pay for the facility fee/supplies and I believe they should because this was the initial emergency repair of the tendon and their cost is so much less than what an emergency room or outpatient facility cost would be. The charge was $75.00…CPT code 26433…the MAR for 26433 in this setting is $796.02. Insurer only paid $789.92 and an additional $6.10 is requested. CPT code A4550 A splint was fabricated for him to wear after surgery and an additional different kind of splint was provided (two splints in all). Medicare does not have an RVU for physicians because it is covered under suppliers. Thus according to rule 134.1 when there is no MAR (no medicare RVU), no contract, then reasonable and fair must be paid."

Amount in Dispute: $91.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In researching CPT code 99070 in the amount of $75.00 we find it is being billed for supplies related to the surgical procedure. No additional recommendation is warranted…In reference to code CPT 26433 we find additional recommendation of $6.10 is correct and a copy of the EOR is attached. After further research pertaining to code A4570 we find we have reviewed and denied appropriately."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2012	CPT Code 99070 for Office Based Surgery Facility Charges	$75.00	$0.00
	CPT Code 26433	$6.10	$0.00
	HCPCS Code A4570 – Splints (X2)	$10.00	$10.00
TOTAL		$91.10	$10.00

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 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires that in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be fair and reasonable.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1-Workers compensation fee schedule allowance.
   - Charge exceeds Fee Schedule allowance.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 18-Duplicate claim/service.
   - 193-Original payment decision maintained.
   - W3-Additional payment made on appeal/reconsideration.

Issues

1. Is the benefit for the disputed service, CPT code 99070, included in the allowance of another service rendered on January 19, 2012?
2. Is the requestor entitled to additional reimbursement for CPT code 26433?

Findings

1. The requestor is seeking dispute resolution for CPT code 99070 for the facility fee for the office based surgery.

   According to the explanation of benefits, the respondent denied reimbursement for CPT code 99070 based upon reason code "97."

   CPT code 99070 is defined as "Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)."

   On the disputed date of service, the requestor also billed for surgical procedures, CPT code 26433.

   28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean 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."

   According to the Medicare Surgery Manual, section 20.4 - Summary of Adjustments to Fee Schedule Computations, "For services after 1995, CMS computes and provides the fee schedule amount for every service discussed above.
   Certain adjustments are made in order to arrive at the final fee schedule amount.
   Those adjustments are:
   - Participating versus nonparticipating differential;
   - Reduction for re-operations;
   - Site of service payment adjustment;
   - Multiple surgeries;
   - Bilateral surgery;
   - Anti-Markup Payment Limitation;
   - Provider providing less than global fee package;
   - Assistant at surgery;
   - Two surgeons/surgical team; and
   - Supplies."

According to the Medicare Surgery Manual, section 20.4.2 - Site of Service Payment Differential, "Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility and nonfacility settings."

The Division finds that per the Medicare Surgery Manual the fee schedule for the surgical procedures , CPT code 26433, has been adjusted for non-facility charges; therefore, the facility fee for the office based surgery is global to the surgical procedures performed. As a result, reimbursement cannot be recommended.

2. In regards to CPT code 26433, the respondent states that additional payment of $6.10 was made; therefore, the dispute has been resolved. As a result, additional reimbursement is not recommended.

3. 28 Texas Administrative Code §134.203 (d)(1) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS"

   The requestor billed for HCPCS code A4570. DMEPOS does not have a fee listed for this code. Per Texas Medicaid the fee allowable is $28.53. Per 28 Texas Administrative Code §134.203 (d)(2), the MAR is $28.53 X 125% = $35.66. The requestor is seeking $10.00; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $10.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $10.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/10/2013
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, 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.