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
ROC ASC LLP

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-1542-01

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
January 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 11043 is appropriate for debridement of fascia tendon, joint capsule and/or muscle."

Amount in Dispute: $276.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed CPT code 11043 under Diagnosis Code 883.0. Diagnosis Code 883.0 refers to an open wound of the finger "without complication." Respondent denied the payment pursuant to Explanation Code "11," indicating that the diagnosis is inconsistent with the procedure. Per the NCCI edits, CPT code 11043 is not warranted for an uncomplicated wound. Requestor failed to bill the service under the appropriate Diagnosis Code, and no further reimbursement is due at this time."

Respondent: White Espey, PLLC, P.O. Box 152949, Austin, TX 78715

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 2013	11043	$276.45	$275.70

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 medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out reimbursement guidelines for medical services, charges and payments.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 11 – The diagnosis is inconsistent with the procedure
   - W1 – Workers compensation state fee schedule adjustment
   - BL – This bill is a reconsideration of a previously reviewed bill

Issues

1. Did the requestor support disputed claim with documentation?

2. What is the applicable rule to calculate reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 11 – "The diagnosis is inconsistent with the procedure." Review of the submitted documentation finds;
    a. CPT code 11043 has a description of, "Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed): first 20 sq cm or less.
    b. Page 2 of operative report finds, "…The skin full thickness was debrided at the edges taking 1mm of skin of skin edge… Subcutaneous tissues were debrided back to stable tissue and devitalized tissue was removed. Hemostasis was achieved. The wound was closed under no tension using 4.0 nylon is simple interrupted fashion."
    c. Review of the NCCI edits finds not conflicts for this code
    d. Review of ODG UR Advisor Entry finds the incidence rate and frequency percentage would suggest very rarely allowed.

    The carrier's denial is not supported. Therefore, the disputed charge will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.402(f) 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:
        (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or
        (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. …

    Review of the submitted documentation finds request for implantables was made and considered by the carrier. The services in dispute will be calculated at the Medicare ASC Facility reimbursement amount multiplied by 153% or

Submitted Procedure Code	National Reimbursement from Addendum AA	Statistical Area Number	Wage Index for ASC	Divide National Reimbursement by 2	Multiply by National Wade Index	Add to National Reimbursement Divided by 2	Medicare Adjusted ASC Reimbursement	Total MAR
11043	$117.64	26420 Houston TX	0.9945	117.53 ÷ 2 = $58.82	58.82 x 0.9945 = 58.50	58.82 + 58.50 = $117.32	$117.32	117.32 x 235% = $275.70
							Total	$275.70

2. The total allowable for the disputed services is $275.70. The carrier paid $0.00. The balance due is $275.70. This amount is recommended.

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 $275.70.

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 $275.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 15, 2015 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.