



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

SURGICAL & DIAGNOSTIC CENTER

Respondent Name

STANDARD FIRE INSURANCE CO

MFDR Tracking Number

M4-15-2958-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

May 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim for \$103,478.33 was billed on 10/21/2014. Partial Payment from Sedgwick in the amount of \$87,126.14 was received on 11/11/2014...We are requested reconsideration for the implants on this claim. We requested separate reimbursement for the implants and provided a certification statement on the cost invoice...CPT Codes 64555 and 49568 were billed with modifier 59 per CCI edits should be payable."

Amount in Dispute: \$27,272.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Responses Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2014	Ambulatory Surgical Care for CPT Code 49568-59	\$27,272.00	\$0.00
	Ambulatory Surgical Care for CPT Code 64555-59		
	HCPCS Code C1767		

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

- 28 Texas Administrative Code §133.307 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:
 - OA-The amount adjusted us due to bundling or unbundling of services.
 - 531-Please re-submit with the appropriate HCPCS/CPT code.
 - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
 - 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.
 - 306-Billing is a duplicate of other services performed on same day.
 - 536-These charges have already been billed and paid for according to fee schedule and/or reasonable guidelines. No further payment is due.
 - W3-Additional payment made on appeal/reconsideration.
 - 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

Is the requestor entitled to additional reimbursement for services rendered October 14, 2014?

Findings

1. 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.”
2. On the disputed date of service, the requestor billed CPT codes 49561, 49568-59, 49507-LT, 64555-59, C1767, and C1781. The respondent paid for all of the services except codes 49568, 64555 and C1767.
3. According to the submitted explanation of benefits, the respondent denied reimbursement for code 49568-59 based upon reason codes “243” and “OA.”
4. Per National Correct Coding Initiative Edits, CPT code 49568 is a component of code 49507; however a modifier is allowed to differentiate the service. A review of the submitted medical billing finds that the requestor appended modifier “59” to code 49568.
5. Modifier 59 is defined as “Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”

A review of the Operative report finds that the requestor did not support support a “different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.” The Division finds that the requestor did not support the use of modifier 59. As a result reimbursement is not recommended for code 49568-59.

6. The respondent denied reimbursement for code 64555 based upon reason code “531.” CPT code 64555 is defined as “Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve).” A review of the Operative report finds that the requestor’s documentation did not meet the definition of code 64555 to support billing. As a result, reimbursement is not recommended.

7. On the disputed date of service, the requestor also billed HCPCS code C1767. This code was denied payment by the respondent based upon reason code "243."
8. HCPCS code C1767 is defined as "Generator, neurostimulator (implantable), nonrechargeable."
9. Per Medicare Addendum BB, code C1767 has a payment indicator of "N1."
10. Medicare Addendum DD1 defines payment indicator of "N1" as "Packaged service/item; no separate payment made."
11. 28 Texas Administrative Code §134.402(d)(1) states in part, "Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program."
12. 28 Texas Administrative Code §134.402(f)(1)(B)(i) and (ii) 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."

The Division finds that even though Medicare does not allow separate reimbursement for code C1767, 28 Texas Administrative Code §134.402 does if separate reimbursement for the implants is requested.

A review of the submitted medical bills finds that the requestor did request separate reimbursement for the implantables.

13. A review of the Operative report finds that the requestor's documentation did not meet the definition of code C1767 to support billing. As a result, 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 disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/5/2015 Date
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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.