



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

CASTLE HILLS ASC LP

Respondent Name

HARTFORD UNDERWRITERS INSURANCE CO

MFDR Tracking Number

M4-16-0412-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

OCTOBER 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received a payment of \$3,159.41. Please reconsider CPT codes 25295 SG and 25295 with modifier 59...Enclosed are copies of the EOB, claim, operative report, and authorization for your review."

Amount in Dispute: \$13,800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Cornerstone Surgery Center contends that it should be reimbursed for procedures which the fee guideline would deny."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2015	Ambulatory Surgical Care for CPT Code 25295-59-SG Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon	\$4,200.00	\$0.00
	Ambulatory Surgical Care for CPT Code 25295-SG Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon	\$7,000.00	\$710.79
	Ambulatory Surgical Care for CPT Code 25280-59-SG Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon	\$2,600.00	
TOTAL		\$13,800.00	\$710.79

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, 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:
 - P12-Workers compensation jurisdiction fee schedule adjustment.
 - Q97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - QS301-This service is included in primary or more extensive procedure.
 - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - W3-Additional payment made on appeal/reconsideration.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
 - QMED-Any reductions are due to charges exceeding amounts reasonable for the providers demographic area.

Issues

1. Is the requestor entitled to additional reimbursement for code 25280-59-SG?
2. Is the allowance of codes 25295 and 25295-59-SG included in the allowance of code 25280-59-SG?

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."

28 Texas Administrative Code §134.402(f)(1)(A) 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."

According to Addendum AA, CPT code 25280 is a non-device intensive procedure.

The City Wage Index for San Antonio, TX is 0.8858.

The Medicare fully implemented ASC reimbursement for code 25280 CY 2015 is \$1,339.58.

To determine the geographically adjusted Medicare ASC reimbursement for code 25280:

The Medicare fully implemented ASC reimbursement rate of \$1,339.58 is divided by 2 = \$669.79

This number multiplied by the City Wage Index is \$593.29.

Add these two together = \$1,263.08.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

$\$1,263.08 \times 235\% = \$2,968.23.$

2. According to the explanation of benefits , the respondent denied reimbursement for codes 25295-SG and 25295-59-SG based upon reason codes “Q97” and “QS301.”

Per CCI edits, CPT code 25295 is a component of code 25280; however, a modifier is allowed to differentiate the service. A review of the submitted medical billing finds that the requestor appended modifier -59 to one of the codes.

Modifier 59’s descriptor is “**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-Evaluation and Management (E/M) services performed on the same day. Modifier 59 is used to identify procedures or 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 or 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 indicates that “Scar connecting skin, subcutaneous tissues and ECRB and ECRL tendons was identified and bluntly and sharply dissected and removed. Meticulous hemostasis was obtained using electrocautery. Significant tendon contracture was noticed. ECRL tendon lengthening was carried out...”

The Division finds that the Operative Report supports the claimant underwent procedures on two tendons. Because both procedures, code 28280 and 25295, were performed to the ECRL tendon, modifier 59 appended to code 25295 is not supported. As a result, reimbursement is not recommended.

The Division finds that the Operative Report supports 25295-SG to the ECRB tendon. Therefore, reimbursement is recommended.

The Medicare participating amount for code 25295 is \$813.76. In addition, code 25295 is subject to multiple procedure discounting.

Using the above formula, the Division finds the MAR is \$901.56.

The total allowable for codes 25280-SG and 25295-SG is \$3,869.79. The respondent paid \$3,159.00. As a result, additional reimbursement of \$710.79 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 \$710.79.

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 \$710.79 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

11/19/2015
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, 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.