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
NORTH GARLAND SURGERY CENTER

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-18-0709-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
NOVEMBER 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $4,262.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money…Per Medicare CCI Edits, CPT 28476 requires a 59 modifier when billed with CPT 28485. Implants are processed separately by ForeSIGHT Medical.

Response Submitted By: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2016	Ambulatory Surgical Care for CPT Code 28476-LT	$1,016.95	$0.00
	Ambulatory Surgical Care for CPT Code 28585-LT	$0.00	$0.00
	Ambulatory Surgical Care for CPT Code 28485-LT-59	$0.00	$0.00
	Ambulatory Surgical Care for HCPCS Code C1713	$2,484.30	$2,189.30
	Implant Interest	$761.00	See Order
Total		$4,262.25	$2,189.30

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:
   - Previous gross recommended payment amount on line: $0; Previous recommended payment amount on line $0.
   - This procedure on this date was previously reviewed.
   - The appropriate modifier was not utilized.
   - National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day.
   - 13-Claim specific negotiated discount.
   - Device payment was based on documentation provided by your facility.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - W3-Additional payment made on appeal/reconsideration.

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?

2. Is the respondent's denial of payment supported for code 28476-LT?

3. Is the requestor due additional reimbursement for HCPCS code L8699 and C1713?

Findings

1. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

2. Per the Table of Disputed Services, the requestor is seeking reimbursement of $1,016.95 for code 28476-LT.

   According to the submitted explanation of benefits, the respondent denied reimbursement for 28476-LT based upon "National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day."

   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. Per Medicare's CCI edits, CPT code 28476 has a conflict with code 28485; however, a modifier is allowed to differentiate the service. Based upon the submitted billing, the requestor did not append the appropriate modifier to differentiate the service. The division finds the respondent's denial of payment for code 28476-LT is supported.

3. The requestor is seeking additional reimbursement of $2,484.30 for HCPCS code C1713. Based upon the submitted explanation of benefits, the respondent paid $5,125.70 based upon a negotiated discount. Neither party to this dispute submitted a copy of a contractual agreement for the negotiated discount; therefore, the reduction is not supported and the disputed services will be reviewed per the fee guideline.

   Based upon the Implant Record and the MediSource Partners, LLC invoice, the division finds the total cost of implants used was $6,650.00.

   28 Texas Administrative Code §134.402(f)(1)(B)(i) states "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."

Implant Description	QTY	Cost per Unit	Total	Total Cost + 10%
Partially Threaded Screw with Washer 4.5 X 48	1	$350.00	$350.00	$385.00
4 hole Plate	2	$1,750.00	$3,500.00	$3,850.00
Locking Screw 2. 3 X 12	6	$350.00	$2,100.00	$2,310.00
Locking Screw 2.3 X 14	1	$350.00	$350.00	$385.00
Locking Screw 2.3 X 10	1	$350.00	$350.00	$385.00
TOTAL			$6,650.00	$7,315.00

The respondent paid $5,125.70. The requestor is due the difference of $2,189.30.

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 $2,189.30.

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 $2,189.30 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	1/18/2018 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.