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
METROCREST SURGERY CENTER

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-18-3184-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2017 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $11,300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On the original bill…this Texas ASC was paid at 235% OPPS with implants not separately payable.

The following CPT/HCPCS codes were billed and denied:

CPT 64910 X 3 units…was denied as this procedure was not performed per CPT definition.

CPT 26170… was denied as this procedure was not performed per CPT definition.

HCPCS C1713 (implants) was denied as these implants were not requested separately on the original bill submission according to the rules of the Texas fee schedule…"

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2017	Ambulatory Surgical Care for CPT Code 64910	$2,873.11	$9,622.91
	Ambulatory Surgical Care for CPT Code 64910	$1,436.55	
	Ambulatory Surgical Care for CPT Code 64910	$1,436.55	
	Ambulatory Surgical Care for CPT Code 26426	$0.00	

	Ambulatory Surgical Care for CPT Code 26170	$529.55	
	Ambulatory Surgical Care for HCPCS Code C1713	$5,522.17	
Total		$11,300.00	$9,622.91

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 (ASC) services.
3. 28 Texas Administrative Code §133.10, effective April 1, 2014, outlines the required billing form and format ASC services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150, 263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - P300-charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage this adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amount (payment and contractual).
   - W3-In accordance with TCI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.

Issues

1. What is the issue in dispute?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. Is the respondent's denial of payment for CPT code 64910 (X3) supported?
4. Is the respondent's denial of payment for CPT code 26170 supported?
5. Is the respondent's denial of payment for HCPCS code C1713 supported?
6. What is the appropriate reimbursement for ASC services rendered on November 14, 2017?

Findings

1. Per the *Table of Disputed Services*, the requestor is seeking additional reimbursement of $11,300.00 for ASC services rendered on November 14, 2017. On the disputed date of service the requestor billed codes 64910 (X3), 26426, 26170 and C1713. Per the *Table of Disputed Services*, the respondent paid $1,425.44 for code 26426 based upon the fee guideline. All other services remain in dispute.
2. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
3. The respondent denied reimbursement for ASC services for CPT code 64910 (X3) based upon "150, 263-The code billed does not meet the level/description of the procedure performed/documented. Consideration

will be given with coding that reflects the documented procedure."

The following statute addresses the coding issue in dispute:

- 28 Texas Administrative Code §134.402(b) (6) states, "Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means 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."
- 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."

CPT code 64910 is described as "Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve." The requestor billed for repair of three (3) nerves.

The requestor wrote in the Operative Report "I proceeded to repair the radial and ulnar digital nerves in the middle finger and radial digital nerve of the ring finger…I achieved the secondary repair with Stryker conduit 2.5 mm, 2 mm, and 3 mm." The division finds the requestor's documentation supports billing CPT code 64910 (X3). As a result reimbursement is recommended.

4. The respondent denied reimbursement for ASC services for CPT code 26710 based upon "150, 263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure."

   CPT code 26710 is described as "Excision of tendon, palm, flexor or extensor, single, each tendon."

   The requestor wrote in the Operative Report "Left index finger flexor digitorum superficialis tendon excision." The division finds the requestor's documentation supports billing CPT code 26710. As a result, reimbursement is recommended.

5. The requestor is also seeking dispute resolution for HCPCS code C1713. The respondent wrote, "HCPCS C1713 (implants) was denied as these implants were not requested separately on the original bill submission according to the rules of the Texas fee schedule."

   28 Texas Administrative Code §133.10(f)(1)(W) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1)The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (W) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line."

   On the medical bill in box # 19, the requestor wrote "153% + (Implant Cost + 10%). The above reference rule requires the request for separate reimbursement to be made on fields 24d-24h not 19. The division finds that the bill was not completed in accordance with 28 Texas Administrative Code §133.10(f)(1)(W). The division concludes the request for separate reimbursement was not in the form and manner required by 28 Texas Administrative Code §133.10(f)(1)(W), and the respondent's position is supported. As a result, reimbursement for HCPCS code C1713 is not recommended.

6. What is the appropriate reimbursement for ASC services rendered on November 14, 2017?

   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."

To determine the maximum allowable reimbursement (MAR) the Division gathered the following factors to be used in the calculations:

According to Addendum AA, CPT code 64910, 26426 and 26170 are non-device intensive procedures.

The City Wage Index for Carrollton, Texas is 0.9895.

Code 64910 (X3)

The fully implemented ASC relative payment weight for code 64910 CY 2017 is $1,884.99.

To determine the geographically adjusted Medicare ASC reimbursement for code 64910:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = $942.49

This number multiplied by the City Wage Index $932.59.

Add these two together = $1,875.08.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $4,406.43.

For the first 64910 the MAR is $4,406.43.

Because this code is subject to multiple procedure rule discounting the second and third unit of 64910 is calculated by $4,406.43 X 50% = $2,203.215 each.

Total for Code 64910 (X3) = $8,812.86

Code 26426

The fully implemented ASC relative payment weight for code 26426 CY 2017 is $1,217.75.

To determine the geographically adjusted Medicare ASC reimbursement for code 26426:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = $608.87

This number multiplied by the City Wage Index $602.47.

Add these two together = $1,211.34.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,846.64.

Because this code is subject to multiple procedure rule discounting it is calculated by $2,846.64 X 50% = $1,423.32.

Code 26170

The fully implemented ASC relative payment weight for code 26170 CY 2017 is $694.86.

To determine the geographically adjusted Medicare ASC reimbursement for code 26170:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = $347.43.

This number multiplied by the City Wage Index $343.78.

Add these two together = $691.21.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $1,624.32.

Because this code is subject to multiple procedure rule discounting it is calculated by $1,624.32 X 50% = $812.17.

The total allowable for disputed services rendered on November 14, 2017 is $11,048.35. The respondent paid $1,425.44. The requestor is due the difference of $9,622.91.

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 $9,622.91.

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 $9,622.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/7/2019
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, 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.