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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICARE AT NORTH DALLAS

Respondent Name
FEDERAL INSURANCE CO

MFDR Tracking Number
M4-18-4833-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
AUGUST 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2018 Texas Workers Compensation Fee Schedule and Guidelines"

Amount in Dispute: $1,282.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has been reimbursed the amount of $3,649.85. The provider is not entitled to any additional reimbursement."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2017	Ambulatory Surgical Care Services (ASC) Code 64704	$0.00	$0.00
	ASC Services for Code 15275	$338.22	$0.00
	ASC Services for Code 14040	$0.00	$0.00
	ASC Services for HCPCS Code Q4104	$2,475.00	$0.00
TOTAL		$1,282.24	$0.00

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, effective May 31, 2012, 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. 28 Texas Administrative Code §133.10, effective April 1, 2014, sets out the required health care provider billing procedures.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59-Processed based on multiple or concurrent procedure rules.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 234-This procedure is not paid separately.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3-Request for reconsideration.

Issues

1. What are the services in dispute?
2. What is the applicable fee guideline for the disputed services?
3. Is the requestor due additional reimbursement for CPT code 15275?
4. Is the respondent's denial of payment for HCPCS code Q4104 supported?

Findings

1. On the disputed date of service, the requestor billed $18,220.00 for CPT codes 64704, 15275, 14040, and Q4104. The respondent paid $3,649.85. Per the Table of Disputed Services, the requestor is only seeking medical fee dispute resolution for codes 15275 and Q4104.
2. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
3. The respondent paid $902.32 for code 15275 based upon reason codes: "59-Processed based on multiple or concurrent procedure rules," "P12-Workers' compensation jurisdictional fee schedule adjustment," and "Z710-The charge for this procedure exceeds the fee schedule allowance." The requestor is seeking additional reimbursement of $338.22.

   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 15275 is described as "Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area."

To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.402(f)(1)(B).

28 Texas Administrative Code §134.402(f)(1)(B) 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 15275 is a non-device intensive procedure.

The Medicare fully implemented ASC reimbursement for code 15275 CY 2017 is $771.98.

To determine the geographically adjusted Medicare ASC reimbursement for code 15275:

The Medicare fully implemented ASC reimbursement rate of $771.98 is divided by 2 = $385.99.

This number multiplied by the City Wage Index for Dallas, Texas is $385.99 X 0.9895 = $381.93.

Add these two together = $767.92.

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

$767.92 X 235% = $1,804.61.

This code is subject to multiple procedure discounting = $1,804.61 X 50% = $902.30.

The respondent paid $902.32. As a result, additional reimbursement is recommended of $0.00.

4. The requestor is seeking separate reimbursement for the implantables with HCPCS Code Q4104. The respondent denied reimbursement based upon reason code "234-This procedure is not paid separately."

   HCPCS code Q4104 is described as "Integra bilayer matrix wound dressing (BMWD), per sq cm."

   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 non-institutional medical bill related to Texas workers' compensation health care: (W) supplemental information (shaded portion of CMS-1500/field 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."

   A review of the submitted medical bill finds the requestor did not indicate on fields 24d-24h a request for separate reimbursement for the implantables. Therefore, the respondent's denial is supported. As a result, the requestor is not due separate reimbursement for codeQ4104.

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

		10/24/2018
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.