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
GRAPEVINE SURGICARE

Respondent Name
HARTFORD FIRE INSURANCE CO

MFDR Tracking Number
M4-19-3333-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
MARCH 1, 2019

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 for Ambulatory Surgical Centers."

Amount in Dispute: $4,791.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 26546 was denied as per NCCI edits; this code is a 'Column 2' code and therefore, is inclusive to CPT 26756."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2018	Ambulatory Surgical Care Services CPT Code 26546-F9	$4,791.07	$4,791.07
	Ambulatory Surgical Care Services CPT Code 26756-F8	$0.00	
TOTAL		$4,791.07	$4,791.07

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 §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §133.10, effective April 1, 2014, sets out the healthcare provider billing procedures.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor) component codes of comprehensive surgery: musculoskeletal system procedure (20000-29999) has been disallowed.
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

Is the allowance of code 26546-F9 included in the allowance for 26756-F8? Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $4,791.07 for ambulatory surgical care services rendered to the injured worker on December 18, 2018. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.
2. Per the submitted explanation of benefits, the insurance carrier denied payment for CPT code 26546-F9 based upon "899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor) component codes of comprehensive surgery: musculoskeletal system procedure (20000-29999) has been disallowed," and "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

3. To determine if the respondent's denial of payment is appropriate the division refers to the following statutes:

   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.

4. The disputed services are defined as:

   > CPT code 26546 is defined as "Repair non-union, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation)." The requestor appended modifier "F9- Right hand, 5th digit" to code 26546.
   >
   > CPT code 26756 is defined as "Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each." The requestor appended modifier "F8- Right hand, 4th digit."

5. Per NCCI edits, CPT code 26546 is mutually exclusive to code 26756; however, a modifier is allowed to differentiate the service. The division finds the requestor appended the "F9" modifier to code 26546 to differentiate the procedure was on a different finger than 26756-F8. The division concludes the requestor

supported position that the respondent's denial based upon reason codes "899" and "97" are not supported and reimbursement is due.

6. Per ADDENDUM AA, CPT code 26546 is a non-device intensive procedure.

   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.

   The following formula was used to calculate the MAR:

   The Medicare fully implemented ASC reimbursement for code 26546 CY 2018 is $2,721.37.

   The Medicare fully implemented ASC reimbursement rate of $2,721.37 is divided by 2 = $1,360.68.

   This number multiplied by the City Wage Index for Dallas, Texas is $1,360.38 X 0.9848 = $1,339.99.

   Add these two together = $2,700.67.

   To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $6,346.57.

7. Per ADDENDUM AA, CPT code 26756 is a non-device intensive procedure.

   The following formula was used to calculate the MAR:

   The Medicare fully implemented ASC reimbursement for code 26756 CY 2018 is $1,279.91.

   The Medicare fully implemented ASC reimbursement rate of $1,279.91 is divided by 2 = $639.95.

   This number multiplied by the City Wage Index for Dallas, Texas is $639.95 X 0.9848 = $630.22.

   Add these two together = $1,270.17.

   To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,984.89. This code is subject to multiple procedure rule discounting of 50% = $1,492.44.

8. The division finds the total allowable for ASC services rendered on December 18, 2018 is $7,839.01. The insurance carrier paid $2,946.12. The difference between MAR and paid = $4,892.89. The requestor is seeking lesser amount of $4,791.07; this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $4,791.07.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $4,791.07, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		04/18/2019
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 Rule §133.307, effective May 31, 2012, *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. **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.