Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MCKINNEY SURGERY CENTER
4510 MEDICAL CENTER DRIVE SUITE 150
MCKINNEY TX 75069

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-09-A151-01

MFDR Date Received
JULY 9, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid per TX workers comp"

Amount in Dispute: $554.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is billing 2 units for both procedures codes as only one procedure is performed with modifier 50 indicating this is bilateral. Per the Medicare Claims processing manual under billing for bilateral procedures:

> If a procedure is not identified by it's terminology as bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier 50. The report procedure as a single line item. (Note this differs from CPT Coding guidelines which indicate that bilateral procedures should be billed as two line items).

The provider billed this incorrectly per the rules established my Medicare; therefore, it was paid appropriately for what was payable."

Response Submitted by: Liberty Mutual Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2009	ASC Services for CPT Code 64475	$327.41	$327.39
	ASC Services for CPT Code 64476 (X2)	$113.54/ea	$227.08
TOTAL		$554.49	$554.47

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 a medical fee dispute.
2. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
3. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. Texas Labor Code §413.011(d-3) states the division may request copies of each contract and that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - P303-This service was reviewed in accordance with your contract.
   - Z547-This bill was reviewed in accordance with your fee for service contract with First Health.
   - 42- Charges exceed our fee schedule or maximum allowable amount.
   - 24- Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - 4- The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - B447-Services billed require a modifier. Please resubmit with a appropriate modifier.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. What is Medicare's policy regarding payment and billing of bilateral procedures performed in ASC?
3. Did the requestor support position that additional reimbursement is due for ASC services for code 64475? Is the requestor entitled to reimbursement?
4. Did the requestor support position that additional reimbursement is due for ASC services for code 64476? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract under which fee are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.

   28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   On October 13, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support

that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon denial reason codes "4 and B447."

   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."

   Per the Medicare Ambulatory Surgery Center Manual regarding Payment and Billing of Bilateral Procedures

   > A procedure performed bilaterally in one operative session should be reported as two procedures. Therefore, Medicare will treat payment for a procedure performed bilaterally the same as payment for multiple procedures.

   The Division reviewed the respondent's position summary and related material and finds that the respondent is relying on guidelines for professional services not Ambulatory Surgery Center services. The Division further finds that the requestor billed the services in accordance with the Medicare Ambulatory Surgery Center Manual; therefore, the respondent's denial based upon reason codes "4 and B447" is not supported.

3. 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."

   CPT code 64475 is defined as "Injection, anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar or sacral, single level. The reimbursement guideline for CPT code 64475 is found at 28 Texas Administrative Code §134.402(f). To determine the maximum allowable reimbursement (MAR) the Division used the following calculations:

   The Medicare fully implemented ASC reimbursement rate is found in the Addendum AA for CY 2009 = 6.7504. This number is multiplied by the 2009 Medicare ASC conversion factor of 6.7504 X $41.393 = $279.41. The Medicare fully implemented ASC reimbursement rate is divided by 2 = $139.70 ($279.41/2).

   This number X City Conversion Factor/CMS Wage Index for McKinney, Texas is $139.70 X 0.9945 = $138.93.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $139.70 + $138.93 = $278.63.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $278.63 X 235% = $654.78.

   Since the injection were performed bilaterally, the MAR is 100% for the primary procedure and 50% for secondary procedures. According to the Table of Disputed Services, only the secondary procedure is in dispute; therefore, $654.78 X 50% = $327.39. The insurance carrier paid $0.00. The difference between amount due and paid equals $327.39, this amount is recommended for reimbursement.

4. CPT code 64476 is defined as "Injection, anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar or sacral, additional level."

   The reimbursement guideline for CPT code 64476 is found at 28 Texas Administrative Code §134.402(f). To determine the maximum allowable reimbursement (MAR) the Division used the following calculations:

The Medicare fully implemented ASC reimbursement rate is found in the Addendum AA for CY 2009 = 2.3409. This number is multiplied by the 2009 Medicare ASC conversion factor of 2.3409 X $41.393 = $96.89. The Medicare fully implemented ASC reimbursement rate is divided by 2 = $48.44 ($96.89/2).

This number X City Conversion Factor/CMS Wage Index for McKinney, Texas is $48.44 X 0.9945 = $48.17.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $48.17 + $48.44 = $96.61.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $96.61 X 235% = $227.03.

Because CPT code 64476 is an add-on code it is not subject to multiple procedure discounting; therefore, the MAR is $227.03. The requestor is seeking reimbursement for two units; therefore, $227.03 X 2 = $454.06. The insurance carrier paid $0.00. The difference between amount due and paid equals $454.06. The requestor is seeking a lesser amount of $227.08; this amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $554.47.

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 $554.47plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		03/21/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.