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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PALLADIUM FOR SURGERY DALLAS

Respondent Name
LIBERTY MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-09-B416-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 12, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Billed Timely and pmt is due"

Amount in Dispute: $281.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Palladium for Surgery Dallas has been appropriately reimbursed for services rendered . . . "

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2009	Procedure codes 64475, 64476	$281.80	$281.80

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 medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the fee guidelines for ambulatory surgical services.
3. The Division takes notice that the requestor has listed the disputed date of service as March 2, 2009 on the requestor's *Table of Disputed Services*. Review of the submitted documentation finds that the actual date of service was March 20, 2009. The Division concludes that the date listed on the requestor's DWC060 form is the result of a typographical error. The Division will therefore deem the disputed date of service to be March 20, 2009 for the purpose of this review.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - U899 – PROCEDURE HAS EXCEEDED THE MAXIMUM ALLOWED UNITS OF SERVICE.
   - U849 – THIS MULTIPLE PROCEDURE WAS REDUCED 50%% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to ambulatory surgical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.402(f), which states that "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"
2. Reimbursement is calculated as follows:
   - Procedure code 64475-50-SG denotes an "Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level." The 2009 Fully Implemented ASC Relative Payment Weight for this procedure of 6.7504 multiplied by the Medicare 2009 conversion factor of $41.393 results in a fully implemented payment amount of $279.42. This amount multiplied by 50% yields an unadjusted labor-related portion of $139.71. This amount multiplied by the annual wage index for the facility location in Dallas, Texas of 0.9945 results in an adjusted labor-related amount of $138.94. The non-labor related portion is 50% of the fully implemented payment rate or $139.71. The Medicare ASC facility reimbursement amount is the sum of the labor and non-labor related amounts for a total of $278.65. This amount is multiplied by the Division's conversion factor of 235% for a payment rate of $654.83. The provider billed this service with modifier 50 indicating bilateral services. Per Medicare payment policy, modifier 50 is not allowed for ASC services on the disputed dates of service; therefore, this modifier is not supported. Procedure code 64475 has a multiple procedure payment indicator of 2, which indicates that standard payment adjustment rules for multiple procedures apply. The first unit of the highest paying procedure is paid at 100%, all other such services are paid at 50%. The provider billed 2 units. The first unit is paid at 100%, the second unit is paid at 50%, or $327.41, for a total MAR of $982.24. This amount is recommended.
   - Procedure code 64476-50-SG denotes an "Injection, anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar or sacral, additional level." The 2009 Fully Implemented ASC Relative Payment Weight for this procedure of 2.3409 multiplied by the Medicare 2009 conversion factor of $41.393 results in a fully implemented payment amount of $96.90. This amount multiplied by 50% yields an unadjusted labor-related portion of $48.45. This amount multiplied by the annual wage index for the facility location in Dallas, Texas of 0.9945 results in an adjusted labor-related amount of $48.18. The non-labor related portion is 50% of the fully implemented payment rate or $48.45. The Medicare ASC facility reimbursement amount is the sum of the labor and non-labor related amounts for a total of $96.63. This amount is multiplied by the Division's conversion factor of 235% for a payment rate of $227.08. The provider billed this service with modifier 50 indicating bilateral services. Per Medicare payment policy, modifier 50 is not allowed for ASC services on the disputed dates of service; therefore, this modifier is not supported. Procedure code 64475 has a multiple procedure payment indicator of 0, which indicates that no payment adjustment rules for multiple procedures apply. Procedure code 64476 is an add-on code that is not subject to multiple procedure payment reduction. The provider billed 2 units multiplied by the payment rate of $227.08 results in a MAR of $454.16. This amount is recommended.
3. The total recommended payment for the services in dispute is $1,436.40. The insurance carrier has paid the amount of $1,152.57 to the health care provider. The requestor is seeking $281.80. This amount is recommended.

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 $281.80.

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 $281.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	November 21, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hEither party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) 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.