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
SOUTH TEXAS AESTHETIC ENHANCEMENT CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO.

MFDR Tracking Number
M4-12-1358-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JANUARY 3, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services rendered were done emergently per surgeon Dr. Charles Polsen. Patient's initial surgery was 03-12-08 where his right pinky was amputated. This claim in question was scar tissue surrounding his nerves; patient was in severe and intense pain, so severe patient was crying uncontrollably thru out the day. Surgeon made him N.P.O. and was placed on his emergently surgery list on 9-8-11."

Amount in Dispute: $34,193.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided outpatient emergency room services associated with a surgical procedure to the claimant 9/8/11 and then billed Texas Mutual codes 26415, 26440, 64702, and 64727. Rule 134.600(p)(2) states that outpatient surgical or ambulatory surgical services require preauthorization unless the services are emergent. Rule 133.2 at (3)(A) defnes a medical emergency…The requestor's documentation does not substantiate that the claimant's report of pain was related to a serious dysfunction of any body organ or par, or that waiting for the preauthorization decision would have placed the claimant's health or bodily functions in serious jeopardy. Absent such documentation the requestor provided surgical treatment without the requisite authorization. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2011	Ambulatory Surgical Care Services CPT Code 26415-F9 CPT Code 26415-F9-59	$4,666.15 $4,665.15	$1,548.97
	Ambulatory Surgical Care Services CPT Code 26440-F9-59 (X2)	$4,510.52 $4,510.52	$0.00
	Ambulatory Surgical Care Services CPT Code 64702-F9-59 (X2)	$4,213.27 $4,213.27	$1,726.61
	Ambulatory Surgical Care Services CPT Code 64727-F9-59 (X2)	$3,706.91 $3,706.91	$1,726.61
TOTAL		$34,193.70	$3,275.58

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 §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §133.10, effective August 1, 2011 sets out the health care providers billing procedures.
5. 28 Texas Administrative Code §134.402, effective September 1, 2008 is the applicable Ambulatory Surgical Care fee guideline.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-197-Precertification/authorization/notification absent.
   - 745-Incorrect lincense number format billed, refer to DWC clean claim guides.
   - 930-pre-authoriztion required, reimbursement denied.
   - CAC-193-Original payment decisionis being maintained. Upon review, it was determined that this claimw as processed properly.
   - 891-No additional payment after reconsideration.

Issues

1. Does the submitted documentation support a medical emergency?
2. What is the appropriate fee guideline?
3. Is the allowance of code 26440-F9-59 included in the allowance of code 26145-F9?
4. Is the requestor entiled to reimbursement for code 26145-F9 and 26145-F9-59?
5. Is the requestor entitled to reimbursement for code 64702-F9-59 (X2)?
6. Is the requestor entitled to reimbursement for code 64727-F9-59 (X2)?

Findings

1. The respondent contends that the requestor is not due reimbursement for the disputed services because preauthorization was not obtained.

   The requestor states "Services rendered were done emergently."

   28 Texas Administrative Code §134.600(c)(1)(A), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

   28 Texas Administrative Code §133.2 (3) defines "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   According to the Operative Note, "This is a young gentleman who presented to me approximately 2 weeks ago complaining of rather intense pain involving a previously amputated digit, the right small finger. The pain was localized to 2 discrete areas where there was definitely a mass palpable in each area corresponding to the ulnar and digital nerve branches. The pain was intense at that time. I consulted with a pain specialist, started the patient on both Neurontin and narcotics, started massage techniques, and the patient presented yesterday afternoon saying that the pain had actually gotten worse. It was so severe and intense and incapacitating that the claimant had cried 3 times that day and actually stated that he would 'cut his finger off' if I could not operate on him emergently…I began the surgey…There were 2 distinct masses of tissue, neuromas were formed at the end both radially and ulnarly of the digital nerve branches, and these were severely encases in scar tissue."

28 Texas Administrative Code §134.600(p)(2) states “Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section.” Based upon the Operative Note, the requestor supported position that the disputed services were a medical emergency per 28 Texas Administrative Code §133.2 (3); therefore, preauthorization was not required for the disputed services.

2. 28 Texas Administrative Code §133.10(f)(1)(U) 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: (U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX').” The requestor noted on the CMS-1500 box 24j that the rendering provider is “ASC130038”. Per the NPI registry, the license number 130038 corresponds to an ambulatory surgical care facility; therefore, 28 Texas Administrative Code §134.402 applies to the services in dispute.

3. 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.”

   On the disputed date of service, the requestor billed 26145-F9, 26145-F9-59, 26440-F9-59, 26440-F9-59, 64702-F9-59, 64702-F9-59, 64727-F9-59 and 64727-F9-59.

   - CPT code 26145 is defined as “Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon.”
   - CPT code 26440 is defined as “Tenolysis, flexor tendon; palm OR finger, each tendon.“
   - CPT code 64702 is defined as “Neuroplasty; digital, 1 or both, same digit.”
   - CPT code 64727 is defined as “Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis).”

   Per the National Correct Coding Initiative, CPT code 26440 is a component of code 26145; however, a modifier is allowed to differentiate the service.

   Modifier 59 is defined as “Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”

   The Operative Report indicates that claimant underwent “Neuroplasty times 2, emergent; Neurolysis times 2, emergent; Tenolysis teimes 2, emergent; and Tenosynovectomy times 2, emergent.”

   A review of the operative report does not support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) to support the use of modifier 59; therefore, the Division finds that CPT code 26440 is a component of 26145 and reimbursement is not recommended.

4. The Operative report supports billing of 26145-F9 and 26145-F9-59; therefore, reimbursement is recommended.

   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.”

According to Addendum AA, CPT code 26145 is a non-device intensive procedure.

The City Wage Index for Garland, Texas in Galveston County is 0.9824.

The Medicare fully implemented ASC reimbursement for code 26145 CY 2011 is $665.00.

To determine the geographically adjusted Medicare ASC reimbursement for code 26145:

The Medicare fully implemented ASC reimbursement rate of $665.00 is divided by 2 = $332.50

This number multiplied by the City Wage Index is $332.50 X 0.9824 = $326.64.

Add these two together $332.50 + $326.64 = $659.14.

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

$659.15 X 235% = $1,548.97. Codes 26145-F9 and 26145-F9-59 are subject to multiple procedure discounting; therefore, $1,548.97 X 50% = $774.48 and $774.49. The respondent paid $0.00. The difference between the MAR and amount paid is $1,548.97 for code 26415-F9 and 26415-F9-59.

5. The requestor billed CPT code 64702-F9-59 twice on the disputed date of service. Based upon the code description "Neuroplasty; digital, 1 or both, same digit" code 64702 shall only be reported once even if both nerves were repaired.

   The Medicare fully implemented ASC reimbursement for code 64702 CY 2011 is $741.26. Using the above formula the Division finds the MAR is $1,726.61.

6. On the disputed date of service, the requestor billed 64727-F9-59 twice. CPT code 64727 is classified as an "add-on" code that describes additional work perfomed in conjunction with the primary procedure. In this case an operating microscope was used for code 64702. Because it is an "add-on" code it is not subject to multiple procedure discounting.

   The Medicare fully implemented ASC reimbursement for code 64727 CY 2011 is $741.26. Using the above formula the Division finds the MAR is $1,726.61. Because reimbursement for code 64702 was allowed once, then, reimbursement for code 64727 is allowed once.

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 $3,275.58.

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 $3,275.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	05/27/2015 Date

YOUR RIGHT TO APPEAL

Either 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.