



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

BRECKENRIDGE SURGERY CENTER

Respondent Name

AMERICAN CASUALTY CO OF READING PA

MFDR Tracking Number

M4-13-0533-02

Carrier's Austin Representative

Box Number 47

MFDR Date Received

OCTOBER 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was authorized by Sedgwick CMS as medically necessary. Please issue payment."

Amount in Dispute: \$18,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is a dispute regarding the extent of the compensable injury. The Carrier filed a PLN 11 on December 27, 2011 accepting only the injury of lumbar sprain/strain. [Attachment 6]. The Respondent contends that the disputed medical fees should not be paid because they are for treatment that is not related to the accepted compensable injury of lumbar sprain/strain. The EOB's enclosed with the Requestors' documentation clearly indicate that the medical bills for nerve block injections for date of service May 31, 2012 were denied because the services were not covered services because they were not deemed a medical necessity by the payor. The treatment is not necessary for the accepted compensable injury which is only a lumbar sprain/strain, according to the enclosed peer review and RME reports."

Response Submitted by: Knott & Doyle, Attorney at Law

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. It lists five rows of ambulatory surgical care for various CPT codes on May 31, 2012, with corresponding dispute and due amounts.

May 31, 2012	Ambulatory Surgical Care for CPT Code 64495-LT	\$3,000.00	\$120.60
TOTAL		\$18,000.00	\$1,517.37

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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240, effective July 1, 2012 sets out the procedure for medical bill processing.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 216-Based on the findings of a review organization.
 - W9-Unnecessary medical treatment based on peer review.
 - 50, 407-These are non-covered services because this is not deemed a medical necessity by the payer.
 - W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - 720-Request for reconsideration reviewed. No further payment recommended.

Issues

1. Does a compensability issue exist in this dispute?
2. Does a medical necessity issue exist in this dispute?
3. Is the requestor entitled to reimbursement for code 64493-RT and 64493-LT?
4. Is the requestor entitled to reimbursement for code 64494-RT and 64494-LT?
5. Is the requestor entitled to reimbursement for code 64495-RT and 64495-LT?

Findings

1. The respondent asserts that reimbursement is not due because "There is a dispute regarding the extent of the compensable injury. The Carrier filed a PLN 11 on December 27, 2011 accepting only the injury of lumbar sprain/strain."

28 Texas Administrative Code §133.240(e)(1) and (e)(2)(C), and (h)(1) addresses the actions that the insurance carrier is required to take during the medical billing process, when the insurance carrier determines that the medical service is not related to the compensable injury.

A review of the submitted explanation of benefits does not support that the respondent denied reimbursement for the disputed ASC services based upon not related to the compensable injury in accordance with 28 Texas Administrative Code §133.240; therefore, the Division finds that a compensability issue does not exist in this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason codes "W9," "50," and "407."

The requestor wrote "Claim was authorized by Sedgwick CMS as medically necessary." In support of the position, the requestor submitted a copy of a preauthorization report that indicates that preauthorization was obtained for CPT codes 64493, 64494 and 64495.

28 Texas Administrative Code §134 .600(l) states "The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued."

The Division finds that the insurance carrier's denial based upon medical necessity is not supported because preauthorization was obtained for the disputed services; therefore, a medical necessity issue does not exist in this 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."

CPT code 64493 is defined as "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level."

"When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, Medicare will allow 100 percent of the highest paying surgical procedure on the claim plus allow 50 percent of the applicable payment rate(s) for the other ASC-covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. The OPSS/ASC Final Rule for the relevant payment year specifies whether a surgical procedure is subject to multiple procedure discounting for that year. Final payment is subject to the usual copayment and deductible provision."

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 64493 is a non-device intensive procedure.

The City Wage Index for Richardson, TX is 0.9525.

The Medicare fully implemented ASC reimbursement for code 64493 CY 2012 is \$300.76.

To determine the geographically adjusted Medicare ASC reimbursement for code 64493:

The Medicare fully implemented ASC reimbursement rate of \$300.76 is divided by 2 = \$150.38

This number multiplied by the City Wage Index is $\$150.38 \times 0.9525 = \143.23 .

Add these two together $\$150.38 + \$143.23 = \$293.61$.

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

$\$293.61 \times 235\% = \689.98 . The respondent paid \$0.00. The difference between the MAR and amount paid is \$689.98.

Because the procedure is subject to multiple procedure discounting, a 50% discount will be taken for the bilateral side = $\$689.98 \times 50\% = \344.99 .

4. CPT code 64494 is defined as "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)."

The Medicare fully implemented ASC reimbursement for code 64494 CY 2012 is \$105.14.

Using the above formula the MAR is \$241.20; however, CPT code 64494 is subject to multiple procedure rule discounting. Therefore, $\$241.20 \times 50\% = \120.60 . The respondent paid \$0.00. The difference between the MAR and amount paid is \$120.60 for the right side. Because it was performed bilaterally, \$120.60 is recommended for the left side.

5. CPT code 64495 is defined as "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)."

The Medicare fully implemented ASC reimbursement for code 64494 CY 2012 is \$105.14.

Using the above formula the MAR is \$241.20; however, CPT code 64494 is subject to multiple procedure rule discounting. Therefore, $\$241.20 \times 50\% = \120.60 . The respondent paid \$0.00. The difference between the MAR and amount paid is \$120.60 for the right side. Because it was performed bilaterally, \$120.60 is recommended for the left side.

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 \$1,517.37.

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 \$1,517.37 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	06/10/2015
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.