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
Jacob Rosenstein

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-13-2319-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In light of the explanation provided and additional documentation, we would ask for your help in resolving this dispute with the carrier for these 3 codes 22554-AS, 63075-AS, and 77002-AS that were not reimbursed for the assistant at surgery bill."

Amount in Dispute: $2,187.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that USMD Hospital/Tami ORR FNP has been appropriately reimbursed for services render to (injured worker) for the 5/10/2012 date(s) of service."

Response Submitted by: Liberty Insurance Corp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2012	Assistant at Surgery Services	$2,187.50	$358.23

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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X263 – The code billed does not meet the level/description of the procedure performed/documented.
   - Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Did the respondent support denial of disputed services?
2. What is the applicable rule regarding fees?

3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, X263 – "The code billed does not meet the level/description of the procedure performed/documented." Per 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Review of the submitted documentation finds the following;
    1. CPT code 63075 is described as, "Discectomy, anterior, with decompression of spinal cord and/or nerve root(s). Including osteophytectomy; cervical, single interspace
    2. Operative report page two and three states in pertinent sections, "a C5-C6 complete discectomy was performed using various curettes and pituitaries." "There were large ostophytes present. These were drilled off with a TPS drill." "Bilateral C5-C6 foraminotomies were performed with good decompression of the exiting C6 nerve roots."

    The Division finds the carrier's decision is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor). Payment calculations are as follows;
    4. Per Medicare policy, procedure code 22554, service date May 10, 2012, may not be reported with the procedure code 63075 billed on this same claim based on National Correct Coding Initiative (NCCI) edits.
    5. Per Medicare policy, procedure code 77002, service date May 10, 2012, may not be reported with the procedure code 22554 on this same claim based on National Correct Coding Initiative (NCCI) edits. Also, per the Medicare Fee Schedule, An assistant surgeon modifier AS is not appropriate for Procedure Code 77002.
2. Per Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, 120.1 - Limitations for Assistant-at-Surgery Services Furnished by Nurse Practitioners and Clinical Nurse Specialists (Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13) "Medicare law at section 1833(a)(1)(O) of the Social Security Act authorizes payment for services that NPs and CNSs furnish as an assistant-at-surgery. Specifically, when a NP or CNS actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the NP's and CNSs' services are eligible for payment as assistant-at-surgery services. For additional policy requirements concerning assistant-at-surgery services furnished by physicians and nonphysician practitioners, see chapter 12, section 20.4.3 of the Medicare Claims Processing Manual, Pub. 100-04. The contractor shall pay covered NP and CNS assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of the 16 percent that a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16 percent of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that NPs and CNSs receive for assistant-at-surgery services ***is 13.6 percent of the amount paid to physicians***. Only the AS modifier must be reported on the claim form when a NP or CNS bills assistant-at-surgery services."

    The Maximum Allowable Reimbursement will be calculated as follows: Medicare Fee Schedule allowable is $1,301.64 x 13.6% = $177.02. This amount is inserted to applicable fee guideline (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price or (68.88 / 34.0376) x 177.02 = $358.23.
3. The MAR for the services that are supported by documentation and payable based on Division rules and guidelines is $358.23. 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 $358.23.

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 $358.23 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2014
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, 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 MDR 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.