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
CENTER FOR MINIMALLY INVASIVE SURGERY

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-15-3632-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 7, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital is entitled to further reimbursement because it provided the authorized, medically necessary laminectomy and discectomy at L4-L5 and decompression at the L5 nerve root. When Liberty Mutual provided authorization, the adjuster did not mention a payment agreement. The authorization was given, and when the Hospital performed the procedure it was acting under the reasonable belief that it would be reimbursed for the services provided."

Amount in Dispute: Is not listed on Table of Disputed Services. The Division considers amount in dispute to be the difference between amount billed and paid of $101,254.38.

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: ""The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 19, 2014	Ambulatory Surgical Care for CPT Code 63030-LT	$50,854.38	$0.00
	Ambulatory Surgical Care for CPT Code 63035-LT	$50,400.00	$0.00
TOTAL		$101,254.38	$0.00

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 §134.600 requires preauthorization for ASC services.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - W3-Additional payment made on appeal/reconsideration.
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - E533-This procedure is not allowed for reimbursement to an Ambulatory Surgery Center.
   - U899-Procedure has exceeded the maximum allowed units of service.
   - U415-Procedure code not reimbursable in an outpatient setting per state or Medicare guidelines.
   - 5-The procedure code/bill type is inconsistent with the place of service.
   - P12-No code description given.
   - X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

1. Is the respondent's denial based upon the procedure code inconsistent with the place of service supported?
2. Does the documentation support a contractual agreement issue exists in this dispute?
3. Does the documentation support billing code 63035-LT?
4. Is the requestor entitled to additional reimbursement for code 63030-LT?

Findings

1. 28 Texas Administrative Code §134.402 (d)(1) 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, including the following paragraphs. (1) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program."

   A review of Addendum AA, ASC Covered Surgical Procedures for CY 2014 finds that code 63030 and 63035 are not listed. Because the requestor obtained preauthorization approval in accordance with 28 Texas Administrative Code §134.600 to perform the surgery at an ASC, the Division's rule takes precedence over any conflicting provision adopted by the Medicare program.

2. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. The "PPO ALLOW" amount on the submitted explanation of benefits denotes a "N/A" discount. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable Division rules and guidelines.

3. On the disputed date of service, the requestor billed CPT codes 63030, and 63035. These codes are defined as:

   - CPT code 63030 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar."

   - CPT code 63035 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s),

including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)."

- The "LT" modifier identifies the procedure was performed on the left side of the body.

According to the explanation of benefits, the respondent denied reimbursement for CPT codes 63035 based upon reason codes "150" and "X263"

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."

The respondent contends that reimbursement is not due because, "The provider was paid for CPT 63030 for the 1 interspace between the L4 vertebrae and the L5 vertebrae. The operative record does not support a laminotomy, discectomy, and decompression at another interspace ('additional interspace'); therefore CPT 63035 was denied."

A review of the operative report finds that the requestor does not support billing for an additional interspace; therefore, the respondent's denial based upon reason codes "150" and "X263" is supported. As a result, reimbursement is not recommended.

4. 28 Texas Administrative Code §134.402(f) 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."

   A review of Addendum AA, ASC Covered Surgical Procedures for CY 2014 finds that code 63030 is not listed; therefore, 28 Texas Administrative Code §134.402(i) applies.

   28 Texas Administrative Code §134.402(i) states "If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:
   (1) The agreement may occur before, or during, preauthorization.
   (2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.
   (3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:
   (A) the reimbursement amount;
   (B) any other provisions of the agreement; and
   (C) names, titles and signatures of both parties with dates.
   (4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1)."

   A review of the submitted documentation finds that the requestor did not submit any documentation that an agreement was reached prior or during preauthorization. The dispute packet did not contain a signed copy of an agreement, that identified the parties to the agreement, or the amount of reimbursement as required by 28 Texas Administrative Code §134.402(i). As a result, additional reimbursement is not recommended for code 63030.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/10/2015
Signature	Medical Fee Dispute Resolution Officer	Date
		12/10/2015
Signature	Health Care Business Management Director	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.