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
IMPERIAL SURGERY CENTER

Respondent Name
CHUBB INDEMNITY CO

MFDR Tracking Number
M4-15-3169-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
MAY 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Full payment of the claim should be issued due to the fact that on 12/12/14, adjustor, Sheri Barron verified that these codes are approved to be performed at Imperial Surgery Center. We also received a letter from Corvel also dated 12/2/14 approving this procedure to be performed at our facility. As a result, the procedure was scheduled and performed on 12/12/14. The procedure was performed in our ASC facility which is normal and customary for this type of procedure and therefore payment should be rendered."

Amount in Dispute: $72,060.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The CPT codes billed by Requestor are not listed as a Medicare covered ambulatory surgical procedure. Additionally, there was no agreement between Requestor and Respondent in accordance with DWC Rule 134.402(i) to perform said procedures at an ASC facility."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2014	Ambulatory Surgical Care for CPT Code 63030-LT	$36,030.00	$0.00
	Ambulatory Surgical Care for CPT Code 63035-LT	$36,030.00	$0.00
TOTAL		$72,060.00	$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 §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 5-Proc Code or Bill Type Inconsistent with POS.
   - Per rule 134.402, this CPT code is not listed in the applicable CMS' table of Covered Surgical Procedures for this DOS.

Issues

Is the requestor entitled to reimbursement for codes 63030-LT and 63035-LT?

Findings

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 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 requestor appended modifier "LT-Left Side" to the codes as indicated above.

According to the explanation of benefits, the respondent denied reimbursement for CPT codes 63030-LT and 63035-LT based upon reason code "5."

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."

A review of Addendum AA, ASC Covered Surgical Procedures for CY 2013 finds that code 63030 and 63035 are not listed; therefore, 28 Texas Administrative Code §134.402(i) applies which 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, reimbursement is not recommended.

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

		07/14/2015
Signature	Medical Fee Dispute Resolution Officer	Date
		07/14/2015
Signature	Medical Fee Dispute Resolution Manager	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.