



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

TEXAS SURGICAL CENTER

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-16-3493-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

JULY 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2016 Texas Ambulatory Surgical Center Fee Schedule."

Amount in Dispute: \$518.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per CCI Guidelines, Procedure Code 64415 [SINGLE NERVE BLOCK INJECTION ARM NERVE] has a CCI conflict with Procedure Code 29825 [ARTHROSCOPY SHOULDER AHESIOLYSIS W/WO MANIP]]. Per CMS CCI guidelines, a modifier is NOT allowed to override the CCI conflict."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|--|-------------------|------------|
| April 13, 2016 | Ambulatory Surgical Care CPT Code 64415 | \$518.43 | \$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.

- B839-In accordance with CMS guidelines, this service does not warrant a separate payment.
- 150-Code description not listed.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.

Issues

Is the allowance of code 64415 included in the allowance of code 29825??

Findings

According to the explanation of benefits, the respondent denied reimbursement for code 64415-59 based upon unbundling policy per Medicare guidelines.

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 codes 29825, 29826 and 64415-59. These codes are defined as:

- 29825-Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation.
- 29826-Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure).
- 64415-Injection, anesthetic agent; brachial plexus, single.
- Modifier 59-Distinct Procedural Service.

Based upon Correct Coding Initiative (CCI),the allowance of CPT code 64415 is bundled to allowance of code 29825, a modifier is not allowed to differentiate the service; therefore, the respondent’s denial based upon unbundling is supported. As a result reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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 additional reimbursement for the services in dispute.

Authorized Signature

| | | |
|-----------|--|---------------------|
| Signature | Medical Fee Dispute Resolution Officer | 08/04 /2016 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.