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
MVP SPECIALIST SURGERY CENTER

Respondent Name
TX ASSOC OF COUNTIES RMP

MFDR Tracking Number
M4-19-3028-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
FEBRUARY 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the data provided and have this claim reprocessed to allow for proper payment."

Amount in Dispute: $8,444.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was reimbursed according… to the Medicare ASC fee schedule with the appropriate WC mark-up. Line 2 for 22515 was denied with CARC code of 97 as the code has a N1 Status indicator which is in not payment per the guidelines. Per Medicare, code 225 has an N1 Status which means: Packaged service/item; no separate payment made. There was a note on the bill that also stated: PROVIDER DID NOT REQUEST SEPARATE REIMBURSEMENT FOR IMPLANTS BILLED, THEREFORE ALLOWANCE @ 235%."

Response Submitted By: CareWorks Managed Care Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 22515	$8,444.00	$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, effective May 31, 2012 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:
   - 97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
   - 18-Exact duplicate claim/service.

Issues

Is the requestor entitled to reimbursement for ASC services, CPT code 22515, rendered on August 10, 2018?

Findings

The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.

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, including the following paragraphs."

CPT code 22515 is described as "Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure).

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."

Per Addendum AA, code 22515 has a payment indicator "N1." Per Addendum DD1, "N1" is defined as "Packaged service/item; no separate payment made."

The division finds the respondent's denial of payment for code 22515 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 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

		2/28/2019
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.