



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

MVP SPECIALIST SURGERY CENTER

Respondent Name

BITCO NATIONAL INSURANCE CO

MFDR Tracking Number

M4-19-3029-01

Carrier's Austin Representative

Box Number 19

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: \$18,163.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "absent from the documents submitted was a request for reconsideration."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2018	Ambulatory Surgical Care Services for CPT 63035-SG-LT and 63035-SG-59-RT	\$18,163.80	\$0.00

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

- 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 142-Charge included in facility fee.
 - 16-SVC lacks info needed or has billing error(s).
 - 18-Duplicate claim/service.

Issues

Did the requestor support position that reimbursement is due?

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 63035 is described as “Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc.”

According to the explanation of benefits, the respondent denied reimbursement for CPT code 63035 based upon “142-Charge included in facility fee,” and “16-SVC lacks info needed or has billing error(s).”

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 2018 finds that code 63035 is 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).”

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

Signature	Medical Fee Dispute Resolution Officer	03/28/2019 Date
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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.