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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MVP Specialist Surgery

Respondent Name
Nederland ISD

MFDR Tracking Number
M4-19-3495-01

Carrier's Austin Representative
Box Number 49

MFDR Date Received
March 19, 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: $12,745.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our position is there is no additional owed. The bill was processed following the Medicare payment methodologies as required per the Texas Guidelines."

Response Submitted by: The Littleton Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2018	63044	$12,745.00	$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 sets out reimbursement guidelines for ambulatory surgical centers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's non payment supported?

Findings

1. The requestor is seeking reimbursement for Code 63044 – "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)" rendered on July 9, 2018 as part of an ambulatory surgical procedure. Code 63042 has zero as amount in dispute and will not be reviewed.

   28 Texas Administrative Code §134.402 (d) states in pertinent part,

   > 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

   The applicable Medicare payment policy is in the Medicare Claims Processing Manual, Chapter 14, Section 20 and states,

   > *The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, and wage indices are available on the CMS Web site at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html.*

   Review of the status indicator of Code 63044 found it to be "N1" which is defined as "packaged service/item; no separate payment made." The carrier's zero payment is supported. No additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

______________________	______________________	April 10, 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 Rule §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 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. **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.