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
AMERICAN INTERSTATE INSURANCE

MFDR Tracking Number
M4-19-3498-01

Carrier's Austin Representative
Box Number 01

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: $1,938.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 64483	<$0.01>	$0.00
	ASC CPT Code 64484	$1,939.00	$0.00
TOTAL		$1,938.99	$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 payment for this service is always bundled into payment of other services and not paid a stand-alone charge.
   - 97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
   - P13- Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
   - OE, 96-The procedure or service has not been assigned a fee schedule payment amount or the amount is zero.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on March 27, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on November 13, 2018?

Findings

1. On the disputed date of service, the requestor billed CPT codes 64483 and 64484. The requestor indicated that an overpayment of $0.01 was made for code 64483. The requestor is seeking reimbursement of $1,939.00 for code 64484.
2. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
3. 28 Texas Administrative Code §134.402(b) (6) states,

   > Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

4. 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.

5. The disputed services are described as:
   - CPT code 64483 is described as "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level."
   - CPT code 64484 is described as "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)."

6. 28 Texas Administrative Code §134.402(f)(1)(B) 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.

   Per ADDENDUM AA, CPT code 64483 is a non-device intensive procedure.

   The following formula was used to calculate the MAR:

   The Medicare fully implemented ASC reimbursement for code 64483 CY 2018 is $350.15.

   This number is divided by 2 = $175.07.

   This number multiplied by the City Wage Index for Houston, TX of 0.9750 = $170.69.

   The sum of these two is the geographically adjusted Medicare ASC reimbursement =$345.76.

   Multiply by the DWC payment adjustment of 235% =$812.53.

   The MAR is $812.53. The insurance carrier paid $812.57. As a result, no additional reimbursement is recommended.

7. Per Medicare fee schedule, Addendum AA for ASC services, code 64484 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 64484 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 reimbursement for the disputed services.

Authorized Signature

		6/13/2019
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.