



**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**

ZURICH AMERICAN INSURANCE CO

**MFDR Tracking Number**

M4-19-3589-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

MARCH 22, 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:** \$2,668.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The provider has been reimbursement \$812.57."

**Response Submitted By:** Flahive, Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 64494	\$2,668.00	\$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:
  - P12-Workers’ compensation jurisdictional fee schedule adjustment.

**Issues**

Is the requestor entitled to reimbursement for ASC services, CPT code 64494, rendered on August 14, 2018?

**Findings**

1. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
2. 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.”
3. The respondent indicated that reimbursement of \$812.57 was made in this case. A review of the submitted explanation of benefits finds that \$812.57 was made for code 64493 and \$0.00 for code 64494.
4. CPT code 64494 is described as “Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure).”
5. Per Medicare fee schedule, Addendum AA for ASC services, code 64494 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 64494 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**

Signature	Medical Fee Dispute Resolution Officer	4/18/2019 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, 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.**