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
SECURITY NATIONAL INSURANCECO

MFDR Tracking Number
M4-19-4848-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
JULY 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please find in closed documents to support separate reimbursement for code 63035. Operative report details decompression of the L4 & L5 nerve roots. Please review the data provided and have this claim reprocessed to allow for proper payment."

Amount in Dispute: $12,368.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor seeks reimbursement for CPT code 63035. However, the attached Medicare payment information clearly states CPT code 63035 is excluded from payment in ASC."

Response Submitted By: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 12, 2018	CPT Code 63035 Ambulatory Surgical Care Services	$12,368.00	$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

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.
   - 661-Based on Medicare guidelines, this service is not considered appropriate treatment to be performed in an ASC setting.
   - 351-No additional reimbursement allowed after review of appeal/ reconsideration.
   - W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issue

Is the requestor entitled to reimbursement for ASC services, CPT code 63035, rendered on November 12, 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. 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; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)."
4. The respondent denied reimbursement for CPT code 63035 based upon "661-Based on Medicare guidelines, this service is not considered appropriate treatment to be performed in an ASC setting."
5. 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 for code 63035.

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 services in dispute.

Authorized Signature

		8/09/2019
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, 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.