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
TEXAS BACK INSTITUTE

Respondent Name
LM INSURANCE CORP

MFDR Tracking Number
M4-19-4994-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed procedure code 64450 for a hardware block. This code is what was authorized per UR and per 2019 CPT Manuel this is the correct code for this procedure. According to Liberty Mutual this code is denied as not documented and the CPT code is incorrect. I have included the 2019 CPT page showing this a valid code and also a copy of the UR authorization as well as the injection report showing this procedure was done."

Amount in Dispute: $167.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider billed 64450 which is for Injection, anesthetic agent; other peripheral nerve or branch. Provider did painful hardware injection. There is not a dedicated code for this procedure. Provider should have billed an unlisted code."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2019	CPT Code 64450	$73.76	$0.00
	CPT Code 64450	$73.76	$0.00
	CPT Code 99152	$20.14	$0.00
Total		$167.66	$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 §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason code:
    - 16, 589-The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed.
    - 267-An itemized billing of the time spent performing this service is needed for further review.
    - 5562-Additional payment will be considered with corrected CPT codes.
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - W3-Additional payment made on appeal/reconsideration.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.

Issues

Does the documentation support billing CPT code 64450? Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed service is found in 28 Texas Administrative Code §134.203.
2. The respondent denied reimbursement for code 64450 based upon "5562-Additional payment will be considered with corrected CPT codes."
3. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean 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 §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

   CPT code 64450 is described as "Injection, anesthetic agent; other peripheral nerve or branch."

   The Operative Report indicates "L4, L5 and S1 pedicle screw hardware area was marked…firm needle contact with the pedicle screw head was made." This procedure does not support the description for code 64450; therefore, the respondent's denial is supported.

5. The respondent denied reimbursement for code 99152 based upon "267-An itemized billing of the time spent performing this service is needed for further review."

   CPT code 99152 is described as "Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older."

   The Operative Report does not support the time spent performing code 99152; therefore, the requestor did not support billing code 99152.

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

		08/22/2019
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.