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
BASSETT SURGERY CENTER

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-21-0320-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 26,2020

REQUESTOR'S POSITION SUMMARY

Please reprocess our claim with/on HCFA-1500 form as your EOB requested."

Amount in Dispute: $34,638.50

RESPONDENT'S POSITION SUMMARY

"The bill for DOS 03/12/20 has been reviewed and no additional payment is due as the bill was denied correctly as CPT 23350 is coded as N1 for ASC Payment Indicator; it is a Packaged Service/Item-no separate payment is made."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 23350 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography	$17,000.00	$0.00
	ASC CPT Code 73040 Radiologic examination, shoulder, arthrography, radiological supervision and interpretation	$17,000.00	$0.00
	ASC CPT Code 99152 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	$368.00	$0.00

	and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older		
	ASC CPT Code A9579 Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml	$10.00	$0.00
March 12, 2020	ASC CPT Code Q9967 Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	$179.00	$0.00
	ASC CPT Code J2001 Injection, lidocaine HCl for intravenous infusion, 10 mg	$52.50	$0.00
	ASC CPT Code A4550 Surgical trays	$16.00	$0.00
	ASC CPT Code A4930 Gloves, sterile, per pair	$13.00	$0.00
TOTAL		$34,638.50	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.10, effective April 1, 2014, sets out the required billing forms and formats.
3. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16-Code description not listed.
   - 8763-Provider type must bill on HCFA-1500 with appropriate CPT codes.
   - W3-Additional payment made on appeal/reconsideration.
   - X598-Claim has been re-evaluated based on additional documentation submitted, no additional payment due.

Issues

Is the requestor entitled to reimbursement for ASC services rendered on March 12, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $34,638.50 for ASC services rendered on March 12, 2020.
2. The requestor originally billed on the UB-04 claim form. The respondent denied reimbursement based upon "8763-Provider type must bill on HCFA-1500 with appropriate CPT codes." 28 TAC §133.10(b) states, "Except as provided in subsection (a) of this section, health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), shall submit paper medical bills for payment on: (1) the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500)." The requestor resubmitted the bill on a HCFA-1500 in accordance with 28 TAC §133.10.
3. The fee guideline for ASC services is found in 28 TAC §134.402.

4. 28 TAC §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.

5. 28 TAC §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.

6. 28 TAC §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.

7. Per Medicare fee schedule, Addendum AA for ASC services, code 23350 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 23350 is supported. As a result, reimbursement is not recommended.

8. The remaining disputed services were not listed in ADDENDUM AA. Per ADDENDUM BB they are ancillary services for which payment is packaged; therefore, no reimbursement is recommended.

9. 28 TAC §133.307(c)(2)(M) states,

   Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute.

   The DWC finds the requestor did not submit any medical records to support the disputed services; therefore, this request for medical fee dispute resolution was not filed in the form and manner required by 28 TAC §133.307.

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	11/18/2020 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 TAC §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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.