Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RITESH R. PRASAD, MD

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-21-1028-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 25, 2021

REQUESTOR'S POSITION SUMMARY

"The main procedure codes (that were pre-authorized) have not been paid."

Amount in Dispute: $2,999.00

RESPONDENT'S POSITION SUMMARY

"The submitted documentation did not include the required documentation, therefore the denial would be upheld."

Response Submitted by: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2020	CPT Code 64493-RT	$1,498.00	$184.45
	CPT Code 64494-RT	$749.00	$146.33
	CPT Code 64495-RT	$752.00	$146.33
TOTAL		$2,999.00	$577.11

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
   - 563-Only one bone graft code is allowed per operative session.
   - 5283-Additional allowance is not recommended as the bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract or carrier decision.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 309-The charge for the procedure exceeds the fee schedule allowance.
   - 252-An attachment/other documentation is required to adjudicate this claim/service.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for CPT codes 64493-RT, 64494-RT, 64495-RT rendered on June 25, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,999.00 for CPT codes 64493-RT, 64494-RT, 64495-RT rendered on June 25, 2020.
2. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:
   - 28 TAC §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."
   - 28 TAC §134.203(b)(1) 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
3. The disputed services are described as:
   - 64493-Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level. The requestor appended modifier RT-right side to this code.
   - 64494-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). The requestor appended modifier RT-right side to this code.
   - 64495-Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure). The requestor appended modifier RT-right side to this code.
4. CPT codes 64493-RT, 64494-RT and 64495-RT:

   The respondent denied reimbursement for CPT codes 64493-RT, 64494-RT and 64495-RT based upon reason codes "563," "252," "309" and "P12." (code description listed above)

   Review of the Procedure Report supports claimant underwent a "Rt. L4-SA Medial/Lateral Branch Blocks under fluoroscopic guidance." The requestor supported billing CPT codes 64493, 64494, and 64495; therefore, payment per the fee guideline is recommended.

Per 28 TAC §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) DWC conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

The requestor noted on the CMS-1500 the Place of Service was “11” for an office setting.

The 2020 DWC Conversion Factor is 60.32

The 2020 Medicare Conversion Factor is 36.0896

Per the CMs 1500, the services were rendered in Tyler, TX; therefore, the Medicare locality is “Rest of Texas”.

Using the above formula, the DWC finds the MAR is:

Code	Medicare Participating Amount	MAR	Insurance Carrier Paid	Amount Due
64493	$170.19	$284.45	$0.00	$284.45
64494	$87.55	$146.33	$0.00	$146.33
64495	$87.55	$146.33	$0.00	$146.33

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $577.11.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $577.11, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/25/2021 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.