TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
DISABILITY & PAIN CONSULTANTS

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-23-0591-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 9, 2021 and May 20, 2022	64483-50, 64484-50 and 62323	$3,180.00	$1,379.82
	Total	$3,180.00	$1,379.82

Requestor's Position

"The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

Amount in Dispute: $3,180.00

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on November 15, 2022. Rule §133.307(d)(1) states that if the division does not receive the response within 14-calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 193 & 90563– Original payment decision is being maintained upon review it was determined that the claim was processed properly.
- P12 & 252 – Workers Compensation jurisdictional fee schedule adjustment.
- 4480 – Recommended allowance has been authorized by the payor.
- 90535 – An attachment and other documentation is required to adjudicate this claim/service.
- 300 – An allowance has been made for a bilateral procedure.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. What is the description of the disputed services?
2. Is the Insurance Carrier's denial reason of 4480 and 200 supported?
3. Is the Insurance Carrier's denial reason of 90535 supported?
4. Does the Medicare MPPR rules and bilateral procedure rules apply?
5. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT codes 64483 and 64484 rendered on December 9, 2021 and CPT code 62323 rendered on May 20, 2022. The insurance carrier denied the disputed services with denial reduction codes indicated above.

   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."

- CPT Code 64483 is described as "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level."
- CPT Code 64484 is described as "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)."
- CPT Code 62323 is described as, "Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance."

The requestor appended modifier -50 to CPT codes 64483 and 64484 to identify a bilateral procedure.

Per CMS polices when billing bilateral procedures, the following CPT Codes 64483 and 64484 both contain a status indicator "1."

"Bilateral Surgery (Modifier 50) Indicator: 1."

"150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules."

Per CMS polices when billing multiple procedures, the following applies to CPT Codes 64483 and 64484:

CPT Code 64483 contains a multiple procedure status indicator of "2."

"Multiple Surgery/Procedure (Modifier 51) Indicator: 2"

"Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage."

CPT Code 64484 contains a multiple procedure status indicator of "0."

"Multiple Surgery/Procedure (Modifier 51) Indicator: zero, No multiple procedure payment reduction (MPPR) rules apply to these procedure codes. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure."

CPT code 62323 contains a multiple procedure indicator "2."

"Multiple Surgery/Procedure (Modifier 51) Indicator: 2"

"Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage."

Review of the medical bill finds that the requestor did not bill/report another procedure on the same day, as a result, the standard payment adjustment rules do not apply.

2. The insurance carrier denied the disputed services with denial reduction codes:
    - 4480 – Recommended allowance has been authorized by the payor.
    - 300 – An allowance has been made for a bilateral procedure.

    A review of the EOBs submitted with the DWC060 request does not support that the disputed services were reimbursed either partially or in full. As a result, the DWC finds that the insurance carriers denial reasons indicated above are not supported.

3. The insurance carrier denied the disputed service with denial reduction code:
    - 90535 – An attachment and other documentation is required to adjudicate this claim/service.

    A review of the medical documentation for both disputed dates of service supports the billing of disputed services 64483, 64484 and 62323. The DWC finds that the insurance carrier's denial reason is not supported. As a result, the disputed services are reviewed pursuant to the applicable rules and guidelines.

4. 28 TAC §134.203 states in pertinent part, "(c) 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…"

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

    CPT codes 64483 and 64484 were rendered on December 9, 2021.

    - The 2021 DWC Conversion Factor is 61.17
    - The 2021 Medicare Conversion Factor is 34.8931
    - Per the medical bills, the services were rendered in zip code 75230; therefore, the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 64483 at this locality is $259.37 for the right side, and $129.68 for the left side.

- Using the above formula, the DWC finds the MAR is $454.69 for the right side and $227.34 for the left side for a total MAR of $682.03.
- The respondent paid $0.00.
- The respondent seeks $1,470.00.
- Reimbursement of $682.03 is recommended for date of service December 9, 2021.

The Medicare Participating amount for CPT code 64484 at this locality is $116.00.

- Using the above formula, the DWC finds the MAR is $203.36.
- The respondent paid $0.00.
- The respondent seeks $660.00.
- Reimbursement of $203.36 is recommended for date of service December 9, 2021.

CPT code 62323 was rendered on May 20, 2022.

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services were rendered in zip code 75230; therefore, the Medicare locality is "Dallas."

The Medicare Participating amount for CPT code 62323 x 1 unit at this locality is $273.96.

- Using the above formula, the DWC finds the MAR is $494.46.
- The respondent paid $0.00.
- The respondent seeks $1,050.00.
- Reimbursement of $494.43 is recommended for date of service May 20, 2022.

5. The DWC finds that the requestor is entitled to reimbursement in the amount of $1,379.82, as a result, this amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $1,379.82 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $1,379.82 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 24, 2023
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office managing the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.