TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
NORTH TEXAS NEUROSURGICAL CONSULTANTS

Respondent Name
LIBERTY MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-23-1672-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
March 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 15, 2022	64494-AS-50	$780.00	$230.09
	Total	$780.00	$230.09

Requestor's Position

"On 1-24-23, the carrier paid the primary code 64493-AS-50 but denied the second code 64494-AS-50 for no preauthorization still. On 2-13-23 I faxed another request for reconsideration for code 64494-AS-50 as it was preauthorized and that proof was attached. On 2-27-23 the carrier still denied the code 64494-AS-50 for payment. This patient had bilateral medical branch blocks at L2-3 and L3-4 which is why 64493-AS-50 and 64494-AS-50 were billed for both levels. Only 1 level (L2/3) was reimbursed 64493-AS-50, so 64494-AS-50 for second level (L3/4) still pending reimbursement for the assistant surgeon bill."

Amount in Dispute: $780.00

Respondent's Position

"We have again reviewed payment for the services of November 15, 2022 by North TX Neurosurgical Consultants and determined that reimbursement was issued according to the guidelines provided by the Texas Medical Fee Schedule. No additional payment is due."

Response Submitted by: Liberty Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 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:

- 5987 – REIMBURSEMENT DENIED FOR MODIFIER.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 305 – THE CHARGE FOR THIS PROCEDURE, MATERIAL, AND OR SERVICE IS NOT NORMALLY BILLED.
- P12 – THE EOB DID NOT CONTAIN A DENIAL DISCRIPTION.

Issues

1. Are the insurance carrier's denial reasons supported?
2. What is the description of CPT Code 64494-AS-50?
3. What rule applies to the reimbursement of the disputed CPT codes?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 64494-AS-50, rendered on November 15, 2022. The insurance carrier denied the disputed CPT code with denial reduction codes 5987 and 305 (description noted above.)

   The insurance carrier states in pertinent part, "Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Report add-on code 64494 or 64495 twice when performed bilaterally. Do not report with modifier 50 per CPT guidelines."

   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."

   Review of CMS, Medicare Coverage Database, Billing and Coding, Article ID A56670 states in pertinent part, "CPT code 64494-AS-50 is described as, "If an initial (64490 or 64493) or

second level add-on (64491 or 64494) paravertebral facet injection procedure is performed bilaterally, report the procedure with modifier -50 as a single line item using one UOS. Do not use modifier RT or LT when performing these procedures bilaterally (modifier -50)."

In addition, "CPT codes 64491, 64492, and 64494, 64495 are intended to report second and third additional levels paravertebral facet joints and not each additional nerve. Facet joint levels refer to the joints that are blocked and not the number of medial branches that innervate them as defined by the AMA CPT Committee."

The DWC finds that the requestor billed in accordance with Medicare payment policies. As a result, the insurance carrier's denial reason is not supported.

2. Rule §134.203 applies to the billing and coding of CPT code 64494-AS-50.

   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.

   The requestor billed the following CPT codes on November 15, 2022, 64493-AS-50, 64494-AS-50, and 99152-AS. The requestor seeks reimbursement for CPT code 64494-AS-50.

   The CPT code descriptors and applicable modifiers are described below.

   - Modifier 50 identifies a bilateral procedure.
   - Modifier AS-Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.
   - 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 modifiers 50 and AS.
   - 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 modifiers 50 and AS.
   - 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 and physiological status; initial 15 minutes… The requestor appended modifier AS.

   Review of the Pain Management Operative Report supports claimant underwent a "Bilateral L2-L3 and L3-L4 medial branch blocks." The DWC finds that the requestor documented the procedure code 64494-AS-50, as a result payment is recommended.

3. 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. The 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 2022 DWC Conversion Factor is 78.37
   - The 2022 Medicare Conversion Factor is 34.6062
   - Per the medical bills, the services were rendered in zip code 76017; therefore, the Medicare locality is "Fort Worth."
   - The disputed service was billed with place of service code "22" to identify that the procedure was performed in an outpatient hospital setting. The facility reimbursement applies.
   - The Medicare Participating amount for CPT code 64494 at this locality is $50.80 for two units = $115.04.
   - Using the above formula, the DWC finds the MAR is $230.09.
   - The requestor seeks $780.00.
   - The respondent paid $0.00.
   - Reimbursement of $230.09 is due.

4. The DWC finds that due to the reasons indicated above, the requestor is entitled to a total reimbursement amount of $230.09. 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 $230.09 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $230.09 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 4, 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 handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 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.