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
North Texas Neurosurgical

Respondent Name
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-23-2998-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
July 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 15, 2022	64494-50	$1,200.00	$139.38
	Total	$1,200.00	$139.38

Requestor's Position

"This patient had bilateral medial branch blocks at L2-3 and L3-4 which is why 64493-50 and 64494-50 were billed for both levels. Only 1 level (L2/3) was reimbursed 64493-50 so 64494-50 for the second level (L3/4) is still pending reimbursement."

Amount in Dispute: $1,200.00

Respondent's Position

"The denial issue to the provider for 64494-50 was message 305. The EOP defines message 305 as the charge for this procedure, material, and or service is not normally billed. The provider must adhere to CPT coding guidelines when billing codes for reimbursement, corrected billing is required by the provider."

Response Submitted by: Liberty Insurance

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC 134.203 sets out the fee guidelines for professional medical services.

Denial Reasons

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

- 300 – An allowance has been made for a bilateral procedure.
- 170 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 305 – The chare for this procedure, material, and or service is not normally billed. For Texas Jurisdiction Claims only, per Texas Labor Code Section 413.031 and 28 Tex. Admin. Code Sections 133.308(H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC-Appointed Independent Review Organization.

Issues

1. Is insurance carrier's position statement supported?

2. What rule is applicable to reimbursement?

3. Is requestor entitled to additional reimbursement?

Findings

1. The respondent states, "The EOP defines message 305 as the charge for this procedure, material, and or service is not normally billed," DWC 28 TAC 134.203 (b) states in pertinent part, for coding, billing, reporting and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing;…"

Review of the applicable Medicare payment policy at www.cms.gov, Article – Billing and Coding:

Facet Joint Interventions for Pain Management (A58350) found,

Diagnostic and Therapeutic Injections: Each facet level in the spinal region is composed of bilateral facet joints (i.e., there are 2 facet joints per level, 1 on the right side and 1 on the left). Unilateral or bilateral facet interventions may be performed during the facet joint procedure (a diagnostic nerve block, a therapeutic facet joint (intra-articular) injection, a medial branch block injection, or the medial branch radiofrequency ablation (neurotomy) in 1 session.

A bilateral intervention is still considered a single level intervention. Each unilateral or bilateral intervention at any level should be reported as 1 unit, with bilateral intervention signified ***by appending the modifier -50.***

Levels: 64490 (cervical or thoracic) or 64493 (lumbar or sacral) reports a single level injection performed with image guidance (fluoroscopy or computed tomography (CT)). Procedures performed under ultrasound guidance are not covered.

64491 or 64494 describes a second level which should be reported separately in addition to the code for the primary procedure. 64491 should be reported in conjunction with 64490 and ***64494 should be reported in conjunction with 64493.***

Based on these instructions, the respondent's position is not supported the disputed services will be reviewed per applicable fee guidelines.

2. 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."

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 62.46 for surgery in a facility.

The 2022 Medicare Conversion Factor is 34.61

Per the CMS 1500, the services were rendered in Arlington, TX; therefore, the Medicare locality is "11".

Medicare facility allowable for this location is $51.49.

Using the above formula, the DWC finds the MAR is: 62.46/34.61 x $51.49 x 150(bilateral

procedure) = $139.38.

3. The total allowable for the disputed service is $139.38. 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.

DWC finds the requester has established that additional reimbursement of $139.38 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to 139.38 reimbursement for the disputed services. It is ordered that Liberty Mutual Fire Insurance must remit to North Texas Neurosurgical $139.38 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 24, 2023 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.