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 and Address

DR MICHAEL MCCANN
PO BOX 4730
HOUSTON TX 77210-4730

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-5586-01

MFDR Date Received
JANUARY 23, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These were Bilateral Procedures we received pmt for 1 procedure and 4 was approved. 64484 is Add on code. 77003 is flurscopic not an epiduragram. 77003 is performed to do injections cant perform injections without 77003."

Amount in Dispute: $583.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG preauthorized a bilateral L4 transforaminal Epidural Steroid injection (one unit), with fluoroscopy under monitored anesthesia. I have attached the preauthorization documents. AIG reimbursed $285.24 of the $3,250.00 billed leaving a disputed amount per the DWC-060 of $583.53. The reimbursement only included the one unit preauthorized, and it the charge for the dye injection should be included in the charge for the steroid injection. We ask that you find the requestor is due no more monies."

Response Submitted by: AIG

Respondent's Supplemental Position Summary dated December 3, 2010: "The AWCA Operations Team reviewed the bill for [Claimant] and confirms the bill was re-priced in accordance with the provider's contracted rate of the lesser of 95% of Billed Charges, 95% of the Allowed Amount. In response to the Texas Department of Insurance's inquiry regarding compliance with 28 Tex. Admin. Code 133.4, Michael McCann, MD has been made aware of his participation status with AWCA since 09/15/2008."

Response Submitted by: Aetna

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2008	CPT Code 64483-RT	$0.00	$0.00
	CPT Code 64483-LT	$248.71	$248.71
	CPT Code 64484-RT	$109.02	$0.00
September 26, 2008	CPT Code 64484-LT	$109.02	$0.00

	CPT Code 77003-76	$0.00	$0.00
	CPT Code 77003-76	$38.46	$0.00
	CPT Code 77003-76	$38.46	$0.00
	CPT Code 77003-76	$38.46	$0.00
TOTAL		$583.53	$248.71

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.

   The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - W1-Workers Compensation state fee schedule adjustment.
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.
   - Paid according to state fee schedule guidelines. Documentation does not support the additional levels billed.
   - Paid according to state fee schedule guidelines bilateral La transforaminal steroid injections. Documentation does not support all lines billed; dye injections for epiduragrams are mutually exclusive to the steroid injection(s).

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Does a preauthorization issue exist in this dispute?
3. Does the documentation support billed service?
4. Was CPT code 77003-76 billed in accordance with fee guideline?
5. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   On November 2, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support

that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. According to the requestor's position summary additional reimbursement is due because "These were Bilateral Procedures we received pmt for 1 procedure and 4 was approved."

   The respondent contends that no further reimbursement is due based upon "AIG preauthorized a bilateral L4 transforaminal Epidural Steroid injection (one unit), with fluoroscopy under monitored anesthesia. I have attached the preauthorization documents."

   28 Texas Administrative Code §134.600 (c)(1)(B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(1) states "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

   A review of the Health Direct, Inc. report dated September 8, 2008 preauthorization was given for "Outpatient Bilateral L4 Transforaminal Epidural Steroid Injection with Fluoroscopy Under Monitored Anesthesia."

   A review of the requestor's billing finds that the requestor billed 64483-RT, 64483-LT, 64484-RT, and 64484-LT. These codes are defined as:

   - CPT code 64483 - "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level."
   - CPT code 64484 - "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)."

   Based upon the preauthorization report, only one level was preauthorized; therefore, a preauthorization issue does exist for the additional level billed with CPT codes 64484-RT and 64484-LT. As a result, reimbursement cannot be recommended for CPT codes 64484-RT and 64484-LT.

3. According to the explanation of benefits, the respondent denied reimbursement for CPT codes 64483-LT, 64484-LT and 64484-RT based upon reason code "150."

   The operative report indicates that "Fluroscopically guided needle localization of the bilateral L4 spinal nerves with transforaminal epidurograms and epidural steroid injections."

   Therefore, the operative report supports billing of CPT codes 64483-RT and 64483-LT. As a result, reimbursement is recommended per applicable Division rules and guidelines.

4. CPT code 77003 is defined as "Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)."

   The requestor appended modifier "76- Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional" to code 77003.

   A review of the submitted billing and EOBs finds that the requestor billed for four units of code 77003-76, and was paid for one. The requestor is seeking additional reimbursement for the three unpaid units.

   Per NCCI manual, "CPT codes 76942, 77002, 77003, 77012, and 77021 describe radiologic guidance for needle placement by different modalities. CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations." Therefore, the requestor was paid appropriately for one unit of CPT code 77003. A review of the Table of Disputed Services finds that the requestor is not disputing the amount of payment of $36.53 issued for CPT code 77003.

5. 28 Texas Administrative Code §134.202(b) states “For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.”

   Per 28 Texas Administrative Code §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 Division had been using this MEI annual percentage adjustment: The 2006 Division 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) Division conversion factor in 2007.”

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

   The 2008 DWC conversion factor for this service is 66.32.

   The 2008 Medicare conversion factor is 38.087

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77054, which is located in Houston, Texas; therefore, the Medicare carrier locality is Houston, Texas.

   Using the above formula, the Division determines the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Total Paid	Amount Due
64483 (X2)	**$293.52**	**$511.10 X 150% for bilateral procedure = $766.65**	**$248.71**	**Requestor is seeking $248.71**
77003	**$67.82**	**$118.09**	**$36.53**	**Requestor is seeking $0.00**

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $248.71.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $248.71 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		03/20/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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