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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON METRO ORTHO AND SPINE SURGERY CTR

Respondent Name
WAUSAU UNDERWRITERS INSURANCE CO

MFDR Tracking Number
M4-15-1697-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
FEBRUARY 3, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual states that for services not normally performed in an ASC, the Hospital should have initiated an agreement between the Hospital and the ASC which covers the reimbursement amount. Contrary to Liberty Mutual's position, the Hospital did attempt to reach an agreement with Liberty Mutual…but Liberty Mutual refused…Additionally, Liberty Mutual's position is that some of the CPT codes our client billed for are bundled or integral with procedures that are not included in the SC Fee Guidelines. However, the Hospital submits all codes separately because they are separate and distinct services. The codes are also listed separately in the ASC Fee Guidelines. Our position is that Liberty Mutual cannot withhold payment by choosing to bundle the services which are in fact separate."

Amount in Dispute: $89,032.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider did not request an agreement for payment of services as required by 28 TAC Chapter §134.402…National Correct Coding Rules and Medicare ASC Guidelines were utilized with the review of this bill. Please note that several codes billed are considered bundled into the non-payable procedures billed.

63042: excluded from Payment in ASC per Medicare Addendum EE 2014.

63043: excluded from Payment in ASC per Medicare Addendum EE 2014.

64493: should not be coded with CPT 63042 (which is not payable) and is considered integral to procedure 63042.

69990: is bundled with CPT 63042.

95937: is bundled with both 63042 and 63043.

76000: is bundled to CPT 63042."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2014	Ambulatory Surgical Care for CPT Code 63042	$52,800.00	$0.00
	Ambulatory Surgical Care for CPT Code 63043	$25,200.00	$0.00
	Ambulatory Surgical Care for CPT Code 64493	$2,582.80	$0.00
	Ambulatory Surgical Care for CPT Code 69990	$4,500.00	$0.00
	Ambulatory Surgical Care for CPT Code 95937	$2,880.00	$0.00
	Ambulatory Surgical Care for CPT Code 76000-TC	$900.00	$0.00
TOTAL		$89,032.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - U415-Procedure code not reimbursable in an outpatient setting per state or Medicare Guidelines
   - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
   - X271-Microscope is included in procedure.

Issues

Is the requestor entitled to reimbursement for codes 63042, 63043, 64493, 69990, 95937 and 76000-TC?

Findings

1. On the disputed date of service, the requestor billed CPT codes 63042, 63043, 64493, 69990, 95937 and 76000-TC. These codes are defined as:

   - CPT code 63042 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar."

   - CPT code 63043 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)."

- CPT code 64493 is defined as "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."
- CPT code 69990 is defined as "Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)."
- CPT code 95937 is defined as "Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method."
- CPT code 76000-TC is defined as "Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy)." The requestor appended the "TC-Technical Component" modifier to code 76000.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT codes 63042, 63043 based upon reason code "U415."

   28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   A review of the operative report does not support billing CPT code 63043 for cervical spine surgery, the claimant underwent lumbar spine surgery at L5-S1.

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor."

   A review of Addendum AA, ASC Covered Surgical Procedures for CY 2014 finds that codes 63042 and 63043 are not listed; therefore, 28 Texas Administrative Code §134.402(i) applies.

   28 Texas Administrative Code §134.402(i) states "If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:
   (1) The agreement may occur before, or during, preauthorization.
   (2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.
   (3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:
   (A) the reimbursement amount;
   (B) any other provisions of the agreement; and
   (C) names, titles and signatures of both parties with dates.
   (4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1)."

   A review of the submitted documentation finds that the requestor did not submit any documentation that an agreement was reached prior or during preauthorization. The dispute packet did not contain a signed copy of an agreement, that identified the parties to the agreement, or the amount of reimbursement as required by 28 Texas Administrative Code §134.402(i). As a result, reimbursement is not recommended for codes 63042 and 63043.

3. According to the explanation of benefits, the respondent denied reimbursement for code 64493 based upon reason code" B291."

   A review of the National Correct Coding Initiative Edits finds that the allowance of code 64493 is included in the allowance of code 63042, a modifier is allowed to be appended to code 64493 to differentiate the

service. A review of the submitted medical bill finds that the requestor did not append a modifier to code 64493. As a result, reimbursement is not recommended because the respondent's denial of payment is supported.

4. The respondent denied reimbursement for code 69990 based upon reason code "X271." Per 28 Texas Administrative Code §134.402(d) system participants shall apply the Medicare payment policies in effect on the date a service. According to *Addendum AA,* code 69990 has a payment indicator of "N1." *Addendum DD1, Final ASC Payment Indicators for CY 2014*, defines payment indicator o "N1" as "Packaged service/item; no separate payment made." Therefore, no reimbursement is recommended for code 69990.
5. The respondent also denied payment for code 76000-TC based upon the fee guideline. According to 28 Texas Administrative Code §134.402(d) system participants shall apply the Medicare payment policies in effect on the date a service. Per *Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2014 (Including Ancillary Services for Which Payment is Packaged) to Reflect Revised Payment Rates Based on Changes to the Medicare Physician Fee Schedule Created by the Bipartisan Budget Act of 2013,* code 76000 has a payment status indicator of "N1." Per *Addendum DD1* payment indicator "N1" is a packaged service. As a result, no reimbursement is recommended.
6. The respondent denied reimbursement for code 95937 based upon reason code "U415." Based upon Medicare payment policies, code 95937 has an ASC payment indicator of "IN." This payment indicator is used for nonsurgical procedures that Medicare does not allow to be performed in an ASC. Per 28 Texas Administrative Code §134.402(d) system participants shall apply the Medicare payment policies in effect on the date a service. Because Medicare payment policies do not allow code 95937 to be performed in an ASC, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		09/02/2015
Signature	Medical Fee Dispute Resolution Officer	Date
		09/02/2015
Signature	Medical Fee Dispute Resolution Manager	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, 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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR 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 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 §141.1(d).

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