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
Texas Spine and Joint Hospital

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-24-1739-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
April 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 11, 2023	64510LT	$2,920.00	$1,538.18
	Total	$2,920.00	$1,538.18

Requestor's Position

"The Hospital thereafter submitted an appeal with updated coding of CPT 64510LT, which corresponds with a) the treatment performed as described in pain management procedure report, and b) the treatment proposed and certified in the genex utilization review letter of 08/28/23. Because the Hospital has a valid authorization on file for the treatment performed, the bill should not have been denied for lacking authorization."

Amount in Dispute: $2920.00

Respondent's Position

"The carrier's position is set out in its EOBs. The carrier maintains its position although it is reviewing the bill once again based upon its receipt of the DWC 60."

Response submitted by: Flahive, Ogden & Latson

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 §134.600 sets out the requirements of prior authorization.
3. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 6998 – ESS Recon Logic
- 90563 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 90950 – This bill is a reconsideration of a previously reviewed bill, allowance amounts reflect any changes to the previous payment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600.
- 5293 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or car…
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.
- 65PFH – Priced using Coventry owned contract.
- 90223 – Workers' compensation jurisdictional fee schedule adjustment.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 90084 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CV: Please submit a clear description of the billed unlisted procedure code.

Issues

1. Did the requestor receive required prior authorization?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment outpatient surgical procedure rendered in August of 2023. The claim was originally billed under miscellaneous code 64999. The insurance carrier denied this claim for lacking information. The requestor submitted a corrected bill as a reconsideration for Code 64510 – Injection, anesthetic agent, stellate ganglion (cervical sympathetic). This claim was denied for lack of prior authorization.

   DWC Rule 28 TAC §134.600 (p)(2) states in pertinent part, "Non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services as defined in subsection (a) section.

   Review of the submitted documentation found "genex" URA Review #6112418 that recommended "Certify", "Recommend prospective request for 1 left C6 stellate ganglion nerve block injection between 7/25/2023 and 11/23/2023 be certified."

   The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants is not applicable. The Medicare facility specific amount will be multiplied by 200 percent.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 64510 has status indicator T and is assigned APC 5443. The OPPS Addendum A rate is $852.18 multiplied by 60% for an unadjusted labor amount of $511.31, in turn multiplied by facility wage index 0.8375 for an adjusted labor amount of $428.22.

  The non-labor portion is 40% of the APC rate, or $340.87.

  The sum of the labor and non-labor portions is $769.09 multiplied by 200% for a MAR of $1,538.18.

3. The total recommended reimbursement for the disputed services is $1,538.18. The insurance carrier paid $0.00. The amount due is $1,538.18. 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 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Ace American Insurance Co must remit to Texas Spine and Joint Hospital $1,538.18 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 9, 2024
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.