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

General Information

Requestor Name
Legent Interventional Pain

Respondent Name
American Zurich Insurance Co.

MFDR Tracking Number
M4-25-1070-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 22, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 21, 2024	64493, 64493	$1,640.85	$1,640.85
March 27, 2024	64635, 64635	$3,065.73	$3,065.73
	Total	$4,706.58	$4,706.58

Requestor's Position

"PLEASE NOTE - THESE CLAIMS DENIED AS EXTENT OF INJURY HOWEVER, THE DR (PROFESSIONAL) CLAIMS WERE PAID. I HAVE MADE MULTIPLE ATTEMPTS TO CONTACT THE ADJUSTER WITH NO RETURNED PHONE CALLS."

Amount in Dispute: $4,706.58

Respondent's Position

"The bills in question were escalated and review completed. Our bill audit company has determined that no further payment is due."

Response submitted by: Gallagher Bassett

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 §133.305 sets out general Medical Dispute Resolution guidelines.
3. 28 TAC §124.2 sets out Insurance Carrier Notification Requirements.
4. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgical centers.

Denial Reasons

The insurance carrier denied payment for the disputed services with the following claim adjustment codes:

- 219 & 5029 – PAYMENT DENIED BASED ON EXTENT OF INJURY.
- 109 & 90147 – CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM TO THE CORRECT PAYER/CONTRACTOR.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 00663 – REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES.
- ZK10 – RESOLUTION MANAGER DENIAL.
- 93 – NO CLAIM LEVEL ADJUSTMENT.

Issues

1. Are the disputed services eligible for review by Medical Fee Dispute Resolution (MFDR)?
2. What rule applies for determining the reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement for the disputed services rendered on February 21, 2024?
4. Is the requestor entitled to reimbursement for the disputed services rendered on March 27, 2024?

Findings

1. A review of the submitted explanation of benefits (EOB) documents submitted finds that the services in dispute were denied payment by the insurance carrier due to "extent of injury" and insurance carrier liability.

28 TAC §133.305(b) states, "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices (PLN) with language and content prescribed by the division. Such notices "… shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

A review of the submitted documentation finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. DWC concludes that based on submitted documentation, there are no outstanding issues of compensability, extent, or liability for the injury. Therefore, the denials based on extent of injury and liability are not supported.

DWC finds that the disputed services are eligible for review by MFDR.

2. A review of the submitted documentation finds that this medical fee dispute involves non-payment for preauthorized services rendered in a licensed ambulatory surgical center on February 21, 2024, and on March 27, 2024.

   DWC finds that Rule 28 TAC §134.402 applies to the reimbursement of the services in dispute.

   DWC Rule 28 TAC §134.402 (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 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor-related share.

   DWC Rule 28 TAC §134.402 (f) states in pertinent part "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…
(1) Reimbursement for non-device intensive procedures shall be:

(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or
(B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:

(i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
(ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

A review of the submitted medical bills finds that the facility did not request separate reimbursement for surgical implantables in this case.

3. The requestor, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $1,640.85 for services rendered on February 21, 2024. The disputed services were billed under CPT code 64493-RT and 64493-LT.

   CPT code 64493 is described as paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) injection(s), diagnostic or therapeutic, with image guidance (fluoroscopy or CT), lumbar or sacral; single level. The provider appended this code with modifiers "LT" and "RT" to indicate left (LT) and right (RT) anatomical sides of the body.

   Procedure Code 64493 has a payment indicator of G2 indicating a non-office based surgical procedure; payment based on OPPS payment weight. DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part "reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent." The following formula is used to calculate the MAR:

   - The Medicare ASC reimbursement for code 64493 for applicable date of service is $472.82.
   - The Medicare ASC reimbursement is divided by 2 = $236.41.
   - This number multiplied by the CBSA index of 0.969, for Ft. Worth-Arlington-Grapevine, TX = $229.08.
   - Add these two together = $465.49, the geographically adjusted Medicare ASC rate.
   - To determine the MAR for the first unit of CPT 64493, multiply the geographically adjusted Medicare ASC reimbursement of $465.49 by the DWC payment adjustment factor of 235% = $1,093.90.
   - Procedure code 64493 is subject to multiple procedure discounting with the second unit billed on the same date of service reduced by fifty percent. Therefore, the MAR for the second unit of code 64493 is $546.95.
   - DWC finds that the total MAR for the disputed services rendered on February 21, 2024, is $1,640.85.

- The insurance carrier paid $0.00.
- DWC finds that the requestor is entitled to reimbursement in the amount of $1,640.85 for the disputed services rendered on February 21, 2024.

4. The requestor, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $3,065.73 for services rendered on March 27, 2024. The disputed services were billed under CPT code 64635-RT and 64635-LT.

   CPT code 64635 is described as destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint. The provider appended this code with modifiers "LT" and "RT" to indicate left (LT) and right (RT) anatomical sides of the body.

   Procedure Code 64635 has a payment indicator of G2 indicating a non-office based surgical procedure; payment based on OPPS payment weight. DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part "reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent." The following formula is used to calculate the MAR:

   - The Medicare ASC reimbursement for code 64635 for applicable date of service is $897.79.
   - The Medicare ASC reimbursement is divided by 2 = $448.90.
   - This number multiplied by the CBSA index of 0.969, for Ft. Worth-Arlington-Grapevine, TX = $434.98.
   - Add these two together = $883.88, the geographically adjusted Medicare ASC rate.
   - To determine the MAR for the first unit of CPT 64635, multiply the geographically adjusted Medicare ASC reimbursement of $883.88 by the DWC payment adjustment factor of 235% = $2,077.12.
   - Procedure code 64635 is subject to multiple procedure discounting with the second unit billed on the same date of service reduced by fifty percent. Therefore, the MAR for the second unit of code 64635 is $1,038.56.
   - DWC finds that the total MAR for the disputed services rendered on March 27, 2024, is $3,115.68.
   - The requestor is seeking $3,065.73 for this disputed date of service.
   - The insurance carrier paid $0.00.
   - DWC finds that the requestor is entitled to reimbursement in the amount of $3,065.73 for the disputed services rendered on March 27, 2024.

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 requestor has established that reimbursement in total amount of $4,706.58 is due.

ORDER

Under Texas Labor Code §§413.031, the DWC has determined the requestor is entitled to reimbursement for disputed services. It is ordered that American Zurich Insurance Co. must remit to Legent Interventional Pain, $4,706.58 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 2, 2025
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.