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

STONEGATE SURGERY CENTER
2501 WEST WILLIAM CANNON DRIVE
AUSTIN TX 78745

Respondent Name
TX PUBLIC SCHOOL WC PROJECT

Carrier's Austin Representative
Box Number 01

MFDR Tracking Number
M4-13-1285-01

MFDR Date Received
JANUARY 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient received authorization for procedure; however when the surgeon revealed more intensive damage that required a slightly different code than originally authorized. The carrier was explained this however will not adjust the allowance of the service performed."

Amount in Dispute: $4,725.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the preauthorization letter in this claim reveals documentation to support that the preauthorization approval was given by IMO, Respondent's utilization review agent, on April 23 and April 25, 2012 for CPT Codes 29877 and 29881. The authorized codes do not include CPT code 29880 in dispute. Additionally, Requestor did not submit any documentation to support preauthorization approval was obtained for CPT code 29880 prior to providing the services in dispute in accordance with Rule 134.600. Furthermore, Requestor's rationale for using CPT code 29880 in the submission of its billing (i.e., the surgery in question revealed more intensive damage and required a different code than originally authorized) is undermined by Dr. Schram's use of preauthorized CPT Code 29881 in his billing as surgeon for the procedure in question. In summary, none of the ICD-9 or CPT codes used by Requestor in its billing match the preauthorization requested for the surgery performed on June 12, 2012. Consequently, Requestor has not established that it is entitled to reimbursement in this claim."

Response Submitted by: Creative Risk Funding, 6100 W. Plano Pkwy., Ste. 1500, Plano, TX 75093Creative Risk Funding, 6100 W. Plano Pkwy., Ste. 1500, Plano, TX 750935

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 12, 2012	CPT Code 29880	$4,725.00	$0.00

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 medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - Does not match pre auth.
   - 167 – This (these) diagnosis(es) is (are) not covered.
   - 18 – Duplicate claim/service.

Issues

1. Was preauthorization received for the services billed?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Labor Code §134.600(f) The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the: (1) specific health care listed in subsection (p) or (q) of this section; (2) number of specific health care treatments and the specific period of time requested to complete the treatments; (3) information to substantiate the medical necessity of the health care requested; (4) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the carrier; (5) name of the provider performing the health care; and (6) facility name and estimated date of proposed health care. 28 Texas Administrative Code §134.600(p)(2) requires that non-emergency health care requires preauthorization for outpatient surgical or ambulatory surgical services; the requestor in this dispute is an ambulatory surgical center.

   Review of the information submitted by the respondent shows the injured employees' surgeon in this dispute requested and received preauthorization for CPT Codes 29877 – Knee Arthroscopy/Debridement and 29881 – Arthroscopy Knee Surgery; however, the surgery revealed more intensive damage that required a slightly different code (CPT Code 29880) than originally authorized. The respondent submitted documentation showing that the surgeon billed the correct CPT Code of 29881 and was reimbursed and showed the requestor billed CPT Code 29880, which was not the preauthorized code.
2. Review of documentation submitted by both parties finds that the services billed by the requestor were not preauthorized; therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		February 14, 2014
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *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 MDR 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.