TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Bone & Joint Center

Respondent Name
Continental Casualty Co

MFDR Tracking Number
M4-15-2206-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 19, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services were denied in error stating CPT code 29888 stating that it was bundled with 29880."

Amount in Dispute: $5,894.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reviewed the charges and our position remains that no additional is due."

Response Submitted by: Broadspire, P.O. Box 14351, Lexington, KY 70512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2014	29888	$5,894.41	$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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D86 – Documentation does not meet the criteria for use of this CPT/HCPC/diagnosis/procedure code or assigned DRG
   - D00 – Based on further review, no additional allowance is warranted

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code D86 – Documentation does not meet the criteria for use of this CPT/HCPC/diagnosis/procedure codes or assigned DRG. 28 Texas Administrative Code §134.203 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." Review of the submitted information finds that the service in dispute is described as;

    a. 29888 - Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction. For an anterior cruciate ligament reconstruction (29888), a 5 cm to 12 cm incision is made on the anterior lower patella and upper tibia. A tunnel is drilled through the tibia into the knee joint. A second tunnel is drilled from inside the knee joint, through the femur. With the aid of the arthroscope for visualization, a new ligament graft is placed in the tibial tunnel and positioned inside the knee joint. The bony ends of the ligament are placed in the tibial and femoral tunnels. The ligament is secured with interference screws in both tunnels.

    b. Review of "Operative Report", finds no documentation to support the procedure as described by the submitted CPT code was performed.

    The insurance carrier's denial reason is supported.

2. The requirements of Rule 134.203 were not met. No payment can be 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

Signature	Medical Fee Dispute Resolution Officer	May 19, 2015 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.