



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

NORTHWEST SURGERY CENTER RED OAK

MFDR Tracking Number

M4-16-0643-01

MFDR Date Received

November 9, 2015

Respondent Name

ARCH INSURANCE CO

Carrier's Austin Representative

Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The authorization is on the claim! The code changed and often happens when a surgery becomes more involved than what the naked eye can predict."

Amount in Dispute: \$2,317.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The current dispute involves the provider changing CPT codes from 26320 to 20680. The procedure was pre-authorized and paid under CPT code 26320. Carrier did not authorize the change in CPT codes or the increase in the payment. The carrier denies that the provider has established pre-authorization for CPT 20680. Carrier maintains its position.

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 18, 2015, 20680-F7, \$2,317.90, \$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 Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 197 – Precertification/authorization/notification absent.
• W3 – Request for reconsideration.

Issues

- 1. Did the requestor obtain preauthorization for the disputed service?
2. Is the requestor entitled to reimbursement?

Findings

- 1. Per 28 Texas Administrative Code §134.600 (p) "Non-emergency health care requiring preauthorization includes... (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

Per 28 Texas Administrative Code §134.600 (a) "The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise... (2) Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care."

Per 28 Texas Administrative Code §134.600 (a) "The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise... (7) Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care."

Review of the preauthorization letter issued by Medinsights, dated August 3, 2015 documents that the Utilization Review Company preauthorized the following "Removal of implant from hand 26320... (Use of 0.5cm Master Graft Bone Putty, use of Fluoroscopy Anesthetic Block, Removal of Retained Painful Hardware Right Long P3 Phalanx (26320) 8/3/15 – 10/3/15."

Review of the CMS-1500 documents the requestor billed for CPT Code 20680-F7, not the preauthorized CPT Code 26320. Per 28 Texas Administrative Code §134.600, the disputed service required preauthorization. The requestor submitted insufficient documentation to support that preauthorization was requested and obtained for disputed CPT Code 20680-F7. As a result, the medical fee dispute resolution section determined that reimbursement couldn't be recommended for the dispute service.

- 2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for disputed CPT code 20680-F7 rendered on August 18, 2015.

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

December 4, 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, 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 prefriere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.