



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

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number

M4-16-2057-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

MARCH 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed for your review is a copy of the American Academy of Professional Coders (NCCI or CCI) edits. Please note that CPT code 29828 does not have any edits attached to it, nor do any of the CPT codes billed for that date of service."

Amount in Dispute: \$2,873.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "arthroscopic biceps tenodesis which was billed was not the documented procedure."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2016	Ambulatory Surgical Care for CPT Code 29828-RT	\$2,873.69	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.

Issues

Does the documentation support billing CPT code 29828-RT?
 Is the requestor entitled to additional reimbursement for code 26541-SG?

Findings

According to the explanation of benefits, the respondent denied reimbursement for code 29828-RT based upon "X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure."

28 Texas Administrative Code §134.402(d) states, " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

CPT code 29828 is defined as "Arthroscopy, shoulder, surgical; biceps tenodesis."

The respondent states that "Supported procedure is 23430 [Open tenodesis of long tendon of biceps]. Per the operative report it states: Access was gained into the glenohumeral joint and arthroscopy was started. Direct visualization easily showed with the scope, an avulsed biceps tendon at the labrum. **At this point, arthroscopy ceased.** The operative report goes on to say an incision was made over the right upper arm.....the subcutaneous tissue was closed with 3-0 Vicryl. The skin closed with 4-0 Prolene. Arthroscopy was started. Provider goes on to complete arthroscopic procedures. I have attached the operative report for your review. Therefore arthroscopic biceps tenodesis which was billed was not the documented procedure."

A review of the Operative Report finds that the documentation supports a more extensive procedure. The Operative Report indicates that the arthroscopy was ceased; therefore, the requestor did not support billing code 29828. As a result, reimbursement is not recommended.

Conclusion

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

 04/07/2016
 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.