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
PARIS SURGERY CENTER

Respondent Name
TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-18-3244-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Received preauthorization #102569 on 6-27-17 for arthroscopic rotator cuff repair 29827…Initial submission of this claim on UB04 claim form…corrected claim form type to HCFA-15000 and faxed with all supporting documentation…The case was coded using dx [redacted]…which was not a compensable injury…**WE ARE REQUIRED TO CODE UP TO THE HIGHEST LEVEL OF SPECIFICITY PER CODING GUIDELINES**…"

Amount in Dispute: $28,922.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent contends that Requestor's billing does not correlate with the operative procedure performed on July 19, 2017. Moreover, Requestor's corrected billing does not match the preauthorized services identified on the notice from IMO dated June 27, 2017. Consequently, Requestor has not established entitlement to reimbursement for services rendered in this claim."

Response Submitted By: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2017	Ambulatory Surgical Care Services (ASC) Code 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair	$22,261.67	$0.00
	ASC Services for Code 64416 Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	$3,699.45	$0.00
	ASC Services for Code 76942	$1,600.00	$0.00

	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation		
	ASC Services for Code 99070 Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	$136.00	$0.00
	ASC Services for HCPCS Code L8699 Prosthetic implant, not otherwise specified	$275.00	$0.00
July 19, 2017	ASC Services for HCPCS Code L8699 Prosthetic implant, not otherwise specified	$620.00	$0.00
	ASC Services for HCPCS Code A4306 Disposable drug delivery system, flow rate of less than 50 ml per hour	$86.60	$0.00
	ASC Services for HCPCS Code J2795 Injection, ropivacaine HCl, 1 mg	$143.70	$0.00
TOTAL		$28,922.42	$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 §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §134.600, effective March 30, 2014, requires preauthorization for ambulatory surgical care services.
4. 28 Texas Administrative Code §133.240, effective March 20, 2014, sets out the medical bill processing and audit procedures.
5. 28 Texas Administrative Code §133.20 sets out the health care providers billing procedures.
6. 28 Texas Administrative Code §133.250 sets out the medical bill processing and audit by insurance carriers procedures.
7. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
8. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
9. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15-The authorization number is missing, invalid, or does not apply to the billed services or provider.7-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
   - 29-The time limit for filing has expired.
   - 146-Diagnosis was invalid for the date(s) of service reported.

Issues

1. What are the services in dispute?
2. Were the disputed services billed timely?

3. Do the disputed services require preauthorization?
4. Were the disputed services billed in accordance with 28 Texas Administrative Code §133.10?
5. Was the diagnosis valid for the disputed date of service?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $28,922.42 for ASC services relating to charges for CPT codes 29827-RT, 64416-59-RT, 76942-TC, 99070, L8699 (X2), A4306, and J2795.
2. According to the submitted explanation of benefits, the respondent denied reimbursement for the disputed services based upon "29-The time limit for filing has expired."

   To determine if the disputed services were submitted timely the division refers to the following statute:

   - 28 Texas Administrative Code §133.20(f) states" Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)."
   - 28 Texas Administrative Code §133.20(g) states " Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."
   - Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."
   - 28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   The requestor initially billed for the disputed ASC services on a UB-04. The respondent notified the requestor that "ASC providers must submit on HCFA-1500 billing form."

   After notification, the requestor submitted the bill for the disputed services on a HCFA-1500. The requestor faxed the bill to respondent on August 22, 2017. This date is within the 95 day deadline. The division finds the respondent's denial based upon reason code "29" is not supported
3. 28 Texas Administrative Code §134.600(p)(2) requires preauthorization for "outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section." The division finds the disputed ASC services required preauthorization.
4. The respondent initially denied reimbursement for the disputed services based upon "15-The authorization number is missing, invalid, or does not apply to the billed services or provider."

   On June 27, 2017, the requestor obtained preauthorization for ASC services for CPT code 29827-Arthroscopic Rotator Cuff Repair. The diagnosis code listed on the preauthorization report is S46.001D. The preauthorization number is 102569.

   28 Texas Administrative Code §133.10(f)(1)(N) states,

   > All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (N) prior authorization number (CMS-1500/field 23) is required when preauthorization, concurrent review or voluntary certification was approved and the insurance carrier provided an approval number to the requesting health care provider

A review of the submitted bill does not list the preauthorization number in field 23 of the bill. The division finds the requestor did not bill for the disputed services in accordance with 28 Texas Administrative Code §133.10(f)(1)(n).

In addition, the requestor is seeking separate reimbursement for the implantables with HCPCS Code L8699.

28 Texas Administrative Code §133.10(f)(1)(W) states,

All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1)The following data content or data elements are required for a complete professional or non-institutional medical bill related to Texas workers' compensation health care: (W) supplemental information (shaded portion of CMS-1500/field 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line."

A review of the submitted medical bill finds the requestor did not indicate on fields 24d-24h a request for separate reimbursement for the implantables.

5. According to the submitted explanation of benefits, the respondent denied reimbursement for the disputed services based upon "146-Diagnosis was invalid for the date(s) of service reported."

   The respondent wrote, "As reflected by the operative report in this claim, 'the specific health care' provided by the Requestor on July 19, 2017 involved surgery for a right shoulder rotator cuff tear. The diagnosis associated with the operative procedure does not correlated with the preauthorized diagnosis, the billed diagnoses or the accepted diagnoses in this claim. Consequently, Respondent is not liable for payment of the services in question."

   28 Texas Administrative Code §134.402(b) (6) states, "Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   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, including the following paragraphs."

   A review of the preauthorization report lists the diagnosis "[redacted]-Unspecified injury of muscle(s) and tendon(s) of the rotator cuff of right shoulder, subsequent encounter."

   The requestor billed the diagnoses [redacted]-Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder, subsequent encounter," and "[redacted]-Other acute postprocedural pain."

   Per the ICD-10CM Official Guidelines for Coding and Reporting, FY 2017, Section (B) **General Coding Guidelines** states:

   (7) **Multiple coding for a single condition** - Multiple codes may be needed for sequela, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

(18) **Use of Sign/Symptom/Unspecified Codes** - Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

The division finds the following:

- The requestor obtained preauthorization approval for code 29827.
- The requestor billed code 29827.
- The preauthorization report lists an unspecified diagnosis to the rotator cuff of the right shoulder ([redacted]).
- The requestor listed diagnoses on the bill of a strain to the rotator cuff of the right shoulder ([redacted]).
- The Operative report indicates "Right Shoulder Rotator Cuff Tear."
- The respondent correctly argues that the diagnosis associated with the operative procedure does not correlate to the billed procedure.
- The respondent's denial of invalid diagnoses is supported.

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	9/14/2018 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.