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 HEALTH ROCKWALL

Respondent Name
INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

MFDR Tracking Number
M4-18-4134-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 29827 LT is a bundled procedure code that has been underpaid after the original bill and reconsideration request."

Amount in Dispute: $5,812.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT Code 29827, arthroscopy, shoulder, surgical, with rotator cuff repair was denied as a rotator cuff repair was not documented in the operative report."

Response Submitted by: Helmsman Management Services LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 22, 2018	Outpatient Hospital Services: CPT code 29827, shoulder arthroscopy with rotator cuff repair	$5,812.98	$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 §134.403 sets out the hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X133 – THIS CHARGE WAS NOT REFLECTED IN THE REPORT AS ONE OF THE PROCEDURES OR SERVICES PERFORMED.
   - Z652 - RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The insurance carrier denied payment for procedure code 29827 (shoulder arthroscopy with rotator cuff repair) using claim adjustment reason code X133 – "THIS CHARGE WAS NOT REFLECTED IN THE REPORT AS ONE OF THE PROCEDURES OR SERVICES PERFORMED."

   The division notes that other related shoulder surgeries/arthroscopic procedures were performed and billed as part of the same encounter; however, CPT code 29827 is the only service in dispute.

   The requestor states that CPT code 29827 has been underpaid.

   The respondent asserts, "a rotator cuff repair was not documented in the operative report."

   The definition of CPT code 29827 is "Arthroscopy, shoulder, surgical; with rotator cuff repair."

   Review of the submitted operative report finds that the rotator cuff is documented as intact on the bursal side with an undersurface tear of the supraspinatus tendon, which was debrided (but not sutured or repaired), after which the surgeon documented the supraspinatus tendon as otherwise intact.

   Debridement (removal of damaged tissue and foreign matter) is a service included in the definition of other procedures performed on the same anatomical location during the same encounter, but which are not in dispute. Moreover, debridement does not qualify as a "repair." The surgeon did not describe anything in the operative report to support that suturing, anchoring or any kind of repair was performed on the rotator cuff. Accordingly, the insurance carrier's denial is appropriate, as the medical record does not support this service as billed.

   Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the division finds the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 27, 2018
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.