Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PARIS SURGERY CENTER

Respondent Name
TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-19-1682-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
NOVEMBER 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary in the dispute packet.

Amount in Dispute: $19,821.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CRF contends that PSC's billing does not match the preauthorized services identified on the notice from IMO dated May 7, 2018. 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
May 10, 2018	Ambulatory Surgical Care Services (ASC) CPT Code 24342-LT	$17,017.00	$5,718.58
	ASC for CPT Code 76000-TC	$1,600.00	$0.00
	ASC for HCPCS Code L8699	$1,204.52	$0.00
TOTAL		$19,821.52	$5,718.58

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, effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
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 specific treatments and services.
4. 28 Texas Administrative Code §133.10, effective April 1, 2014, sets out the healthcare provider billing procedures.
5. Per the submitted explanation of benefits, the services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - 284-Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.
   - Diagnosis on preauthorization does not match billing or operative report.
   - 150-Payer deems the information submitted does not support this level of service.
   - 16-Claim/service lacks information or has submission/billing error(s).
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

1. What is the applicable fee guideline for the disputed services?
2. Does a preauthorization issue exist?
3. Was the denial of payment due to invalid diagnosis supported?
4. Does the documentation support billed services?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $19,821.52 for ambulatory surgical care services rendered to the injured worker on May 10, 2018. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.

2. The insurance carrier denied reimbursement for the disputed services, CPT codes 24342-LT, 76000-TC and L8699, based upon "284-Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services."

   Per 28 Texas Administrative Code §134.600(f) (1-3), "The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

   (1) name of the injured employee;

   (2) specific health care listed in subsection (p) or (q) of this section;

   (3) number of specific health care treatments and the specific period requested to complete the treatments."

   28 Texas Administrative Code §134.600(p)(2) requires preauthorization for ''(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   Per 28 Texas Administrative Code §134.600(f)(2) the disputed services required preauthorization because are a specific health care listed in subsection (P)(2) - ambulatory surgical care services.

   On May 7, 2018, the respondent's representative, Injury Management Organization (IMO), gave preauthorization approval for procedure code "24342-Reinsertion/Repair Bicep/Tricep Tendon" to be performed at Paris Surgery Center.

   The division finds the respondent's denial of payment is not supported because requestor obtained preauthorization for ambulatory surgical care services for principal procedure code 24342.

3. The insurance carrier also denied reimbursement for the disputed services based upon "Diagnosis on preauthorization does not match billing or operative report." The respondent wrote, "As reflected by the operative report in this claim, the 'specific health care' provided by Requestor on May 10, 2018 involved surgery for a distal biceps tendon rupture. The diagnosis associated with the operative procedure does not correlated with the preauthorized diagnosis in this claim. Consequently, Respondent is not liable for payment of the services in question."

28 Texas Administrative Code §134.600(d) states, "The insurance carrier is not liable under subsection (c)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury."

The May 7, 2018 report from IMO lists ICD-10 diagnosis code "S46.212-A-Strain of muscle, fascia and tendon of other parts of biceps, left arm, initial encounter." The IMO report notes the surgery is necessary for "ODG Indications for Surgery--Ruptured distal biceps tendon surgery."

The medical bill lists ICD-10 diagnosis code "M66.822-Spontaneous rupture of other tendons, left upper arm." A review of the Operative Report lists diagnosis as "Distal biceps tendon rupture, left."

The division finds the respondent gave preauthorization approval for ambulatory care services for "Ruptured distal biceps tendon surgery." Furthermore, per 28 Texas Administrative Code §134.600(d) the respondent is liable for preauthorized services unless a final adjudication had been made that this diagnosis was not compensable. The respondent did not support that the disputed treatment was not for the compensable injury; therefore, the denial of payment based upon the diagnosis not matching is not supported.

4. Per the submitted explanation of benefits, the insurance carrier also denied payment for the disputed services based upon "150-Payer deems the information submitted does not support this level of service," and "16-Claim/service lacks information or has submission/billing error(s)."

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.

The disputed services are defined as:

- CPT code 24342 is defined as "Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft."
- CPT code 76000 is defined as "Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time."
- HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

The division reviewed the submitted documentation and finds:

- CPT code 24342:

  The Operative Report supports billed service; therefore, the respondent's denial of payment based upon reason codes "150" and "16" is not supported. The division finds the requestor is due reimbursement per the division fee guideline.

- CPT code 76000:

  The National Correct Coding Initiative Policy Manual for Medicare Services Chapter 1, (J), effective January 1, 2018, defines "separate procedure" as "If a CPT code descriptor includes the term "separate procedure", the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

  A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach.

Modifier 59 or a more specific modifier (e.g., anatomic modifier) may be appended to the "separate procedure" CPT code to indicate that it qualifies as a separately reportable service."

The Division finds that because code 76000 has the parenthetical statement "separate procedure" the CCI policy applies. Based upon the Operative Report, code 76000 was performed at the same anatomically related region as the other procedures performed on the disputed date. In addition, the requestor did not bill with appropriate modifier per CCI policy to indicate that it qualified as a separately reportable service. The division finds the respondent's denial of payment is supported; therefore, reimbursement is not recommended.

- 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 implantable. The division finds the respondent's denial of payment is supported; therefore, reimbursement is not recommended.

5. To determine the appropriate reimbursement for non-device intensive procedure CPT code 24342 the division refers to28 Texas Administrative Code §134.402(f)(1)(B).

   28 Texas Administrative Code §134.402(f)(1)(B) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

   The following formula is used to determine the MAR:

   - Per Addendum AA, the Medicare ASC reimbursement for code 24342 on the disputed date is $2,721.37.
   - To determine the geographically adjusted Medicare ASC reimbursement for code 24342 the rate is divided by 2 = $1,360.68.
   - This number multiplied by the City Wage Index for Paris, Texas is $1,360.68 X 0.7884 = $1,072.76.
   - Add these two together = $2,433.44.
   - Multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $5,718.58.
   - The respondent paid $0.00.
   - The requestor is due the difference between the MAR and amount paid of $5,718.58.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $5,718.58.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,718.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/7/2019
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 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 prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.