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
NW SURGERY CENTER RED OAK

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-2448-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
JANUARY 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The undersigned is requesting payment for CPT code 64702 in the amount of $1822.64. Per CCI 2018 edits in which I have included for your review, there is no conflict, no -59 is needed. Based on this information, SORM incorrectly paid this claim."

Amount in Dispute: $1,822.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization obtained under I183542…determined medical necessity for procedure codes 64831, 64910, and 26418 to be performed between 4/25/18-5/31/18. In review of the disputed charges the Office determined that CPT 64702 was not preauthorized."

Responses Submitted By: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 27, 2018	Ambulatory Surgical Care (ASC) for CPT Code 64702-F6	$1,822.64	$0.00
	Ambulatory Surgical Care for CPT Code 26418-F6	$0.00	$0.00
TOTAL		$1,822.64	$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, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.600, effective March 30, 2014, sets out the procedure for preauthorization of specific services.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
   - 6545-Precertification/authorization/notification absent.
   - 131-Claim specific negotiated discount.
   - 197-Recommended allowance based on negotiated discount/rate.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for ASC services, CPT code 64702-F6 rendered April 27, 2018?

Findings

1. The requestor billed $7,826.00 for ASC services for CPT code 64702-F6. The respondent paid $0.00 based upon a lack of preauthorization. The requestor is seeking reimbursement of $1,822.64 for CPT code 64702-F6.
2. 28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."
3. On April 25, 2018, the respondent's agent, Injury Management Organization, gave preauthorization approval for ASC services , CPT codes 26418, 64831 and 64910.
4. The division finds the requestor did not submit any evidence to support preauthorization was obtained for CPT code 64702-F6; therefore, the respondent's denial of payment is supported. As a result, reimbursement is not recommended.

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

		03/06/2019
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, 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.