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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
North Central Surgical Center

Respondent Name
Tx Public School WC Project

MFDR Tracking Number
M4-20-1081-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
December 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that authorization was requested for CPT 29889 under authorization# 124990 which is the only payable code based on J1 status indicators. According to TX fee schedule, the highest J1 code should be paid which the expected reimbursement for CPT 29889 is $21,427.76 making CPT 29880 inclusive, and not separately payable."

Amount in Dispute: $38,024.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor's billing does not match the preauthorized services identified on the preauthorization determination letters from IMO with the exception of ICD-10 code S83.242A (medial meniscus tera). However, that ICD-10 codes does not correlate with the principal operative procedure performed on April 26, 2019. Consequently, Requestor has not established that it is entitled to reimbursement for services rendered in this claim."

Response Submitted by: Creative Risk Funding, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 26 – 27, 2019	Outpatient Hospital Services	$38,024.32	$21,088.34

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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim

adjustment codes:

- 197 – Payment denied/reduced for absence of precertification/authorization
- 284 – Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the respondent's position supported?
2. Is the insurance carrier's denial supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states, "ICD-10 codes does not correlate with the principal operative procedure performed on April 26, 2019." Review of the "Operative Report" indicates, "The area of the meniscal tears, both medically and laterally, were debrided back to stable borders with the use of a biter and shaver. These were recurrent tears on top of prior partial medical and lateral meniscectomies."

   Based on the above, the respondent's position is not supported.

2. The requestor is seeking reimbursement in the amount of $38,024.32 for outpatient hospital services rendered on April 26 – 27, 2019

   The insurance carrier denied the disputed service based on lack of prior authorization. Review of the submitted documentation found an IMO authorization numbered 202312 issued April 23, 2019 for procedure code 29889. The insurance carrier's denial is not supported for this code. This code will be reviewed per the applicable DWC fee guideline.

3. 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators. The Medicare payment policy and DWC fee guideline is found below.

   28 TAC §134.403 (f) states the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.*
   The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent unless separate reimbursement for implants in requested. Review of the medical bill found no separate request for implants was made.

   - Procedure code 29889 has status indicator J1, and is paid at a comprehensive rate. When more than J1 procedure is billed, the highest-ranking code receives reimbursement. The ranking of Code 29889 is 148 which is the highest of the submitted codes.

     This code is assigned APC 5115. The OPPS Addendum A rate is $10,713.88, multiplied by 60% for an unadjusted labor amount of $6,428.33, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $6,258.62. The non-labor portion is 40% of the APC rate, or $4,285.55. The sum of the labor and non-labor portions is $10,544.17. The Medicare facility specific amount of $10,544.17 is multiplied by 200% for a MAR of $21,088.34.

The total recommended reimbursement for the disputed services is $21,088.34. this amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $21,088.34.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $21,088.34, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		February 26, 2020
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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