TDI Division of Workers' Compensation
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Amended Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
BAYLOR SCOTT & WHITE

Respondent Name
TEXAS PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-20-2476-02

Carrier's Austin Representative
Box Number 1

DWC Date Received
June 3, 2020

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 11, 2019	23472-LT	$2,601.41	$2,601.41
	Total	$2,601.41	$2,601.41

Requestor's Position

In summary… inpatient services were clearly authorized by IMO as indicated in the amended authorization letter. CRF failed to properly process this claim and submit payment to BSWH for the authorized inpatient services. Again, BSWH obtained authorization for [redacted] inpatient services and billed the claim to CRF."

Amount in Dispute: $2,601.41

Respondent's Position

"CRF contends that Baylor did not bill Dr. Racusin's surgical services consistent with its request for preauthorization in this claim. Consequently, it is not entitled to reimbursement for the services in question."

Response Submitted by: Creative Risk Funding

Amended Findings and Decision

Authority

By Official Order Number 6695 dated February 26, 2021, the undersigned has been delegated authority by the Commissioner to **amend** fee dispute decisions.

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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.

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out preauthorization, concurrent utilization review, and voluntary certification of health care.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 284 - Precertification/authorization/notification/pre-treatment number may be valid, but docs do not apply to the billed services.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 - Reconsideration/Appeal Notes: RECONSIDERATION PREAUTHORIZATION #126724 WAS FOR OUTPATIENT SERVICES. SERVICES RENDERED ARE INPATIENT. PREAUTHORIZATION #126890 WAS AMENDED 06.13.2019 AFTER SERVICES WERE RENDERED.

Issues

1. What is the definition of CPT Code 23472?
2. Was preauthorization obtained for the service in dispute?
3. Is the Insurance Carrier's denial reason(s) supported?
4. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 23472 rendered on June 11, 2019. The insurance carrier denied the disputed service due to lack of preauthorization.

   The disputed services are professional services rendered in a facility. The CMS-1500 documents that the disputed services were rendered with place of service code 21, which indicates that service rendered were inpatient.

   28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits…"

   CPT Code 23472 is defined as "Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement.)"

2. The insurance carrier denied CPT Code 23472 with denial code 284, (description above.)

   28 TAC §134.600(p)(10) states, "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section…"

   28 TAC §134.600 (q) states, "The health care requiring concurrent utilization review for an extension for previously approved services includes: (1) inpatient length of stay…"

   28 TAC §134.600 (r) states, "The requestor and insurance carrier may voluntarily discuss health care that does not require preauthorization or concurrent utilization review under subsections (p) and (q) of this section respectively… (2) The insurance carrier may certify health care requested. The carrier and requestor shall document the agreement. Health care provided as a result of the agreement is not subject to retrospective utilization review of medical necessity."

   The requestor provided a copy of a preauthorization letter issued by IMO, dated July 7, 2019, which states in pertinent part, "IMO… has preauthorized medical necessity for Open reduction internal fixation of left shoulder with possible reverse total shoulder arthroplasty to be done on an outpatient basis."

   The requestor provided a copy of an amended preauthorization determination letter issued by IMO on 6/13/2019 and requested on June 12, 2019, while the patient was still in the hospital. The preauthorization letter states, "IMO has preauthorized medical necessity for Inpatient Stay x 3 days for reverse total arthroplasty of left shoulder to be done on an inpatient basis."

   28 TAC §134.600 (c) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur… (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or… (2) or per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section."

   The date of service in dispute is June 11, 2019, the patient was discharged on June 12, 2019. The DWC finds that the requestor obtained preauthorization pursuant to 28 TAC §134.600 (r). As a result, the requestor is entitled to reimbursement for the service in dispute.

3. 28 TAC §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) … For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…"

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2020 DWC Conversion Factor is 75.7
- The 2020 Medicare Conversion Factor is 36.0896
- Per the medical bills, the services were rendered in Marble Falls, TX; therefore, the Medicare locality is "Rest of Texas."
- The Medicare Participating amount for CPT code 23472 at this locality is $1,437.84.
- Using the above formula, the DWC finds the MAR is $3,015.95.
- The respondent paid $0.00.
- The Requestor seeks $2,601.41
- Reimbursement of $2,601.41 is recommended for date of service June 11, 2019.

4. The DWC finds that the requestor is therefore entitled to reimbursement in the amount of $2,601.41 for CPT Code 23472 rendered on June 11, 2019.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $2,601.41 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $2,601.41 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 31, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.