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
Houston Methodist San Jacinto

Respondent Name
TX Public School WC Project

MFDR Tracking Number
M4-20-2785-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
July 27, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This in an outpatient bill that should pay per Medicare OPPS fee schedule, per TDI Rule 134.403."

Amount in Dispute: $5,360.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although Houston Methodist requested preauthorization for the surgery services in question under CPT code 29881, its billing included both CPT codes 29879 and 29881. According to Medicare payment guidelines, CPT 29879, which was not preauthorized, is the primary procedure code. The secondary CPT code 29881 bundles into the primary code."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 6 – 14, 2020	Outpatient Hospital Services	$5,360.91	$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 reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.600 sets out the prior authorization requirements for outpatient surgical procedures.
4. 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
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

Is the insurance carriers' denial supported?

Findings

The requestor is seeking reimbursement in the amount $6,360.91 for outpatient hospital services rendered January 6 – 14, 2020. The insurance carrier denied the disputed Code 29881 based on bundling.

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 disputed Code 29881 is one of two surgical procedures performed on January 14, 2020. Both Codes 29881 and 29879 have a status indicator of J1. The Medicare payment policy applicable to multiple J1 procedures indicates, "*When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service*." The ranking of Code 29881 found at www.cms.gov is 1,823. The ranking of Code 29879 is 1,691. Code 29879 is the highest ranking and would receive the single payment.

Review of the submitted IMO authorization dated December 12, 2019 indicates only CPT 29881 was preauthorized. 28 TAC §134.600 (p) (2) states in pertinent part, prior authorization is required for non-emergency outpatient surgery. The insurance carrier's denial is supported. No additional payment can be 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 not established payment 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

Signature	[redacted] Medical Fee Dispute Resolution Officer	August 24, 2020 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.