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
CORPUS CHRISTI OUTPATIENT

Respondent Name
TEXAS PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-21-0926-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
FEBRUARY 2, 2021

REQUESTOR'S POSITION SUMMARY

"Creative Risk Funding has denied reimbursement for this billed procedure based on medical billing diagnosis not matching authorization. Prior to surgery authorization was requested & obtained, authorization was requested & obtained, authorization # 135264 for CPT code 29881 with diagnosis [redacted] However, based on doctor's dictation and notes, procedure codes 29882 and 29879 were added at the time of billing and has been properly coded based on type of treatment performed….although all procedure codes were not authorized prior, everything performed was medically necessary."

Amount in Dispute: $5,852.55

RESPONDENT'S POSITION SUMMARY

"CRF contends that Requestor's billing does not match the preauthorized services identified on the notice from IMO dated January 28, 2020. 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
February 14, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 29881	$2,926.29	$2,926.29
	ASC for CPT Code 29882	$1,463.13	$0.00
	ASC for CPT Code 29879	$1,463.13	Not eligible for Dispute Resolution
TOTAL		$5,852.55	$2,926.29

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.305 sets out general medical dispute resolution guidelines.
2. 28 TAC §141.1 sets out the procedure for requesting a Benefit Review Conference.
3. Texas Labor Code (TLC) §408.021 sets out provisions regarding entitlement to medical benefits.
4. TLC §413.031 sets out provisions regarding medical dispute resolution.
5. TLC Chapter 410 sets out provisions regarding adjudication of disputes.
6. 28 TAC §133.307, effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
7. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
8. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
9. 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.
   - Authorization was for diagnosis [redacted]-Other tear of [redacted] Medical billing diagnosis does not match authorization.
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - W3-Reconsideration/Appeal.
   - 219-Based on extent of injury.
   - 216-Based on the findings of a review organization.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

1. Does MFDR have jurisdiction to review CPT code 29879-LT?
2. Is the requestor entitled to reimbursement for ASC services rendered on February 14, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $5,852.55 for ambulatory surgical care services rendered to the injured worker on February 14, 2020.
2. The fee guidelines for disputed services is found in 28 TAC §134.402.

   28 TAC §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 TAC §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 29879 is defined as “Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture.”
   - CPT code 29881 is defined as “Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.”
   - CPT code 29882 is defined as “Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral).”

3. The respondent denied reimbursement for CPT code 29879 based upon “219-Based on extent of injury,” and

"216-Based on the findings of a review organization."

28 TAC §133.305(b) requires If a dispute regarding compensability, extent of injury, or liability exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, or liability shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §408.021 and Chapter 410.

Upon review of the submitted information, the DWC finds the insurance carrier has denied payment for the health care related to CPT code 29879 for reasons related to the compensability, extent of injury or liability for the disputed services. The carrier's explanation of benefits was timely presented to the requestor in accordance with the requirements of 28 Texas Administrative Code §133.240.

The DWC concludes there is an outstanding dispute regarding the extent of injury or liability for the disputed services billed under CPT code 29879. Consequently, the medical fee issues in dispute are not eligible for review until the related extent of injury or liability issues have been finally adjudicated in accordance with the provisions of Texas Labor Code Chapter 410.

Notice

The DWC hereby notifies the requestor that the process for resolving disputes regarding the extent of injury or liability for health care is found in Texas Labor Code Chapter 410 and corresponding DWC rules in 28 Texas Administrative Code Chapter 141.

To resolve this matter, the requestor may file the required **Form DWC045**, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC), or to Proceed Directly to Contested Case Hearing (CCH)* with the field office handling the claim. A copy of Form DWC045 may be downloaded from the TDI-DWC website at www.tdi.texas.gov/forms/.

RIGHT TO RE-FILE FOR CPT CODE 29879

28 Texas Administrative Code §133.307(f)(3) states that a dismissal is not a final decision by the DWC. The requestor has the right to submit a new request for medical fee dispute resolution after the compensability, extent of injury, or liability issues have been resolved.

The requestor is responsible for filing any new request for medical fee dispute resolution not later than one year after the dates of service in dispute or not later than 60 days after the date the requestor receives an approved agreement or final decision resolving the disputed compensability, extent of injury, or liability issues.

The 60-day filing requirement described in Rule §133.307(c)(1)(B)(i) extends the one-year MFDR filing deadline in those cases where a related compensability, extent of injury, or liability dispute has been filed under Texas Labor Code Chapter 410 for the same services subject to medical fee dispute.

CONTACT

Questions? Call CompConnection for HealthCare providers, toll free at 800-252-7031 option 3 or email MDRInquiry@tdi.texas.gov

4. The insurance carrier denied reimbursement for the disputed services, CPT codes 29881 and 29882 based upon "284-Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services," "Authorization was for diagnosis [redacted]-Other [redacted] of [redacted]. Medical billing diagnosis does not match authorization," and "197-Payment denied/reduced for absence of precertification/authorization."

   Per 28 TAC §134.600(f) (1-9), "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.

   (4) information to substantiate the medical necessity of the health care requested;

(5) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the insurance carrier;

(6) name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting preauthorization;

(7) name, professional license number or national provider identifier of the health care provider who will render the health care if different than paragraph (6) of this subsection and if known;

(8) facility name, and the facility's national provider identifier if the proposed health care is to be rendered in a facility; and

(9) estimated date of proposed health care."

28 TAC §134.600(f) (1-9) does not require the provider to list the diagnosis on the request for preauthorization.

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

Per 28 TAC §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 January 28, 2020, the respondent's representative, Injury Management Organization (IMO), gave preauthorization approval for CPT code 29881 stating, "IMO has preauthorized medical necessity for Left Knee Arthrorscopy with Meniscal Debridement to be done on an Outpatient basis."

The DWC finds the respondent's denial of payment for CPT code 29881 is not supported because the requestor obtained preauthorization for ambulatory surgical care services for code 29881. The requestor did not support preauthorization approval was obtained for CPT code 29882. As a result, reimbursement for CPT code 29882 is not recommended.

5. To determine the appropriate reimbursement for non-device intensive procedure CPT code 29881, the DWC refers to 28 TAC §134.402(f)(1)(B).

28 TAC §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 was used to calculate the MAR:

- The Medicare ASC reimbursement for code 29881 CY 2020 is $1,286.26.
- The Medicare ASC reimbursement is divided by 2 = $643.13.
- This number multiplied by the City Wage Index for Corpus Christi, Texas of 0.9362= $602.10.
- Add these two together = $1,245.23.
- To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $2,926.29.
- The respondent paid $0.00.
- The requestor is due the difference between the MAR and amount paid of $2,926.29.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $2,926.29.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $2,926.29 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		03/04/2021
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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.