Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-22-0149-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
September 23, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 9, 2021	C1762	$577.25	$0.00
	Total	$577.25	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "The charges were not paid correctly according to TX workers compensation guidelines.

Amount in Dispute: $577.25

Respondent's Position

…the implant being billed is for amniotic fluid and tissue which was not authorized.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.600 sets out the billing requirements of professional medical claims.

Denial Reasons

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

- 5920 – These services were delivered for a non-authorized surgical procedure. As the surgeon failed to obtain pre-authorization for the primary procedure. By extension all ancillary procedures (such as anesthesia) lack the prerequisite authorization as well and are not separately reimbursable. Pre-authorization was not obtained for the primary surgical procedure therefore the anesthesia services are denied
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
- 905 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component. Code of comprehensive pathology/laboratory services procedure (8000-89999) has been disallowed

Issues

1. Is the insurance carrier's denial based on lack of authorization supported?

Findings

1. The requestor is seeking reimbursement of an implant that was included in an outpatient surgical procedure rendered in February 2021. The insurance carrier states the primary procedure was not authorized.

   Review of the MediCall UR determination found, "The prospective request for 1 Arthroscopy, Medial/Lateral Meniscectomy, Chondroplasty, Synovectomy, Loose Body Removal, Possible Lateral Release for the Right Knee between 01/21/2021 to 03/22/2021 is certified."

   Review of the operative report from February 9, 2021, found the listed procedures as,

   1. Right knee arthroscopy with partial medical and lateral meniscectomies
   2. Major synovectomy
   3. Chondroplasty of the medial, lateral, and patellofemoral joint spaces
   4. Loose body removal
   5. Bone marrow aspirate concentrate injection and Cellgenuity amniotic fluid injection to right knee.

   DWC Rule 134.600 (p) (2) states in pertinent part non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

   The operative report states, "All fluid is then removed from the patient's knee through the scope. The portal sites are closed by the first assistant using #2-0 nylon in a simple type fashion. The first assistant now injects the knee with the bone marrow aspirate concentrate and Cellgenuity amniotic fluid.

The insurance carrier's denial is supported as the disputed service was administered after the authorized procedures were complete. No additional payment is recommended.

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.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 15, 2021 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.