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
Shannon Medical Center

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-16-1013-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Shannon Medical Center to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the new fee schedule that took effect in March of 2008 for this outpatient surgery."

Amount in Dispute: $3,617.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 25652 (Open treatment of ulnar styloid fracture) was denied as this charge was not reflected in the report as one of the procedures/services performed."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 2015	25652	$3,617.77	$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 §133.210 sets out requirements for medical documentation.
3. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained.
   - B12 – X133 – This charge was not reflected in the report as one of the procedures or services performed

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable reimbursement guideline?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed service with claim adjustment reason code B12 – X133 – This charge was not reflected in the report as one of the procedures or services performed.

   28 Texas Administrative Code §133.210 (b) states,

   > When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.
   >
   > > (c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:
   > >
   > > > (2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;

   The requestor did submit a copy of the required medical documentation in compliance with above stated rule.

   The service in dispute is code 25652 – "Open treatment of ulnar styloid fracture". Review of the submitted "Operative Report" finds

   - Procedure performed: (1) Open reduction internal fixation of left distal radial metaphyseal fracture (2) Open reduction internal fixation of left distal radial shaft fracture.

2. 28 Texas Administrative Code §134.403 (d) states, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section,"

   - Procedure code 25652 cannot be recommended for reimbursement as insufficient information was found to support the disputed service code as billed in comparison to required medical documentation.

3. Pursuant to requirements of Rule 134.403 (d) no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 11, 2016 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 Texas Administrative Code §133.307, 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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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