Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TRINITY PARK SURGERY CENTER
3501 MATLOCK ROAD
ARLINGTON TX 76015

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-0961-01

MFDR Date Received
NOVEMBER 16, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Should pay 50% of TX Work Comp Rate due to multiple procedure rule."

Amount in Dispute: $963.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This NON HCN provider billed 27630 (Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle] as The code billed does not meet the level/description of the procedure performed/documented. The Provider excised hypertrophic bone and resected synovium; no mention of lesion of tendon sheath is documented in the operative report. The Primary surgeon billed CPT 27610 which is the correct CPT code for the services."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2010	ASC Services for Code 27630	$963.56	$0.00

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.

Issues

Does the documentation support billed service? Is the requestor entitled to reimbursement?

Findings

28 Texas Administrative Code §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."

On the disputed date of service, the requestor billed CPT code 20680 and 27630. The respondent denied reimbursement for code 27630 based upon reason code "X263."

CPT Code 27630 is defined as "Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle."

A review of the operative report finds that the claimant underwent "Removal of intramedullary pin from the right fibula; and right ankle arthrotomy with debridement and removal of hypertrophic bone."

The Division finds that the documentation does not support the billed service under CPT code 27630. As a result, reimbursement is not 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

		03/28/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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