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 and Address

DAVID V DENT MD
5501 BALCONES DR NO 310
AUSTIN TX 78731

Respondent Name
Wal Mart Associates Inc

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-12-3641-01

MFDR Date Received
August 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier denied L8680 wanting another code used. Code they asked for is for hosp. related services."

Amount in Dispute: $33,482.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As TDI/DWC rules exist for payment of implantables associated with surgical procedures, applying these rules to the payment of L8699 Trial Stimulator would provide the most recognized, published, fair & reasonable payment for similar work & resources."

Response Submitted by: Hoffman Kelley, 5316 Hwy 290 West, Suite 360, Austin, Texas 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2012	L8680	$33,482.00	$7,714.26

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 medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 5101 – PLEASE REFER TO NOTE ABOVE FOR A DETAILED EXPLANATION OF THE ADDITIONAL INFORMATION NEEDED TO PROCESS YOUR BILLING

- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION

Issues

1. Was the submitted code valid on date of service?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service with note"L8680 is not code of choice for test leads. Per Boston Scientific, & HCPCS code descriptor, the correct reporting would be C1897 LEAD NEUROSTIMULATOR TEST KIT." Per 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; …and other payment policies in effect on the date a service is provided…"The medical bill for the service in dispute included HCPCS code L8680, defined as "Implantable neurostimulator electrode, each". Review of the submitted documentation finds nothing to support a "kit" was provided but rather that sixteen single electrodes were used. Also carrier claims another code of L8699 should have been used. This code description is for the trial stimulator not for the electrodes which are in dispute. The division finds the carrier's denial is not supported. Therefore, this service will be reviewed per applicable rules and fee guidelines.

2. Per 28 TAC Code **§**134.202 (c)(2)(A**)** states in pertinent part, "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; For services in 2012, the maximum allowable reimbursement = (DMEPOS Fee Schedule / 125%) or DMEPOS Fee Schedule = $428.57 x 16 units = $6,857.12 x 125% = 7,714.26

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7,714.26

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 Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,714.26 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January , 2014
Signature	Medical Fee Dispute Resolution Officer	Date
		January , 2014
Signature	Medical Fee Dispute Resolution Manager	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, 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 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 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 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.