



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

Access Mediquip LLC

Respondent Name

American Casualty Co of Reading

MFDR Tracking Number

M4-13-1817-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...Kirby Surgical Center did not bill nor did they provide the implants. Access Mediquip, L.L.C., should be reimbursed separately..."

Amount in Dispute: \$6,068.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has issued payment I the amount of \$1,576.30 as payment in full for the bill after careful review of all of the Rule 134.404(g) documents."

Response Submitted by: Brain J Judis, 700 N Pearl, Suite 425, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2012	L8699	\$6,068.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402 sets out reimbursement guidelines for surgical implant provider.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - A1 – Claim/Service denied
 - Bill has been cancelled
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - B12 – Services not documented in patient's medical records

Issues

- Did the requestor provide documentation to support reimbursement of implantables?
- Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.402(f)(2)(B) states in pertinent part, “If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission;...” 28 Texas Labor Code §134.402(b)(2) define implantable as, “Implantable” means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program and recharge the implantable. Review of the certified invoice finds the following;

Description	Units	Price	Maximum Allowable Reimbursement (MAR)	Total Allowed	Carrier Paid
SCREW CORTICAL 3.5X12MM	2	\$108.00 ea	$\$108.00 \times 2 = \$216 \times 10\% = \$237.60$	\$237.60	\$237.60
SCREW CORTICAL 3.5X14MM	2	\$108.00	$\$108.00 \times 2 = \$216 \times 10\% = \$237.60$	\$237.60	\$237.60
DRILL BIT 2.5MM	1	\$119.00	Not eligible for review. Not supported by operative report as implantable	\$0.00	n/a
DVR ANATOMIC NARW SHORT RIGHT	1	\$1,001.00	$\$1,001.00 \times 10\% = \$1,101.10$	\$1,101.10	\$1,101.10
DRILL BIT FAST 2.0MM	1	\$119.00	Not eligible for review. Not supported by operative report as implantable	\$0.00	n/a
K-WIRE	3	\$45.00	No invoice included in documentation	\$0.00	n/a
PEG DRIVER 2.0MM FAST	2	\$48.00	Not eligible for review. Not supported by operative report as implantable	\$0.00	n/a
PEG SMOOTH 2.0X12MM	1	\$108.00	Not eligible for review. Not supported by operative report as implantable	\$0.00	n/a
PEG SMOOTH 2.0X18MM	1	\$108.00	Not eligible for review. Not supported by operative report as implantable	\$0.00	n/a
PEG SMOOTH 2.0X22MM	3	\$108.00	Not eligible for review. Not supported by operative report as implantable	\$0.00	n/a
PEG SMOOTH 2.0X24MM	1	\$108.00	Not eligible for review. Not supported by operative report as implantable	\$0.00	n/a
Total				\$1,576.30	\$1,576.30

2. The total MAR for the disputed services is \$1,576.30. The carrier paid \$1,576.30. No additional reimbursement is 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

Date

June 10, 2014

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.