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

DENNIS SLAVIN MD
910 E 8TH ST STE 1
WESLACO TX 78596

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-14-1502-01

MFDR Date Received
JANUARY 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code L8680 is being denied for 'this procedure was not paid since the value of this procedure in [sic] INCLUDED/BUNDLED within the value of another procedure performed' Please reprocess this bill immediately. As per TDI this code should not be 'bundled', the L8680 code which is the neurostimulator is the main component of the procedure. I have attached supporting documentation, please review and reprocess promptly..."

Amount in Dispute: $8,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy. 270, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2013	HCPCS Code L8680 – Implantable neurostimulator electrode, each	$8,000.00	$8,000.00

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 §134.203 sets out the guidelines for reimbursement of professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247 – A payment or denial has already been recommended for this service.
   - PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patients responsibility

unless the workers compensation state law allows the patient to be billed.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 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.
- QA – The amount adjusted is due to bundling or unbundling of services.

Issues

1. Are the disputed services bundled into another procedure?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied HCPCS Code L8680, defined as "Implantable neurostimulator electrode, each", using denial codes 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated"; 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; and QA – "amount adjusted is due to bundling or unbundling of services. Per 28 Texas Administrative Code §134.203(b) 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules; and (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1)125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. HCPCS Code L8680 is not considered a bundled item and is paid at $432.04 x 125% = $540.05 each. The requestor in this dispute used 16 L8680 electrodes; therefore, reimbursement is due the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $8,000.00.

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 $8,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 12, 2014 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.