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
Baylor Surgicare

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-16-1774-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
February 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2015 Texas Ambulatory Surgical Center Fee Schedule."

Amount in Dispute: $1,304.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Treatment Code 064718 as reconsidered and Carrier made the allowable reimbursement of $877.90 on 3/11/16. Treatment Code 64510 was denied because according to the NCCI coding edits from CMS, this procedure is included in CPT 26055, which was paid in the allowable amount of $779.12."

Response Submitted by: Smith & Carr P.C., 9235 Katy Freeway, Suite 200, Houston, TX 77024

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2015	64510, 64718	$1,304.18	$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 §134.402 sets out reimbursement guidelines for services performed in ambulatory surgical centers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – Processed based on multiple or concurrent procedure rules

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- W3 – Request for reconsideration
- P12 – Workers' compensation jurisdictional fee schedule adjus
- 193 – Original payment decision is being maintained.

Issues

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

Findings

1. The insurance carrier denied disputed service Code 64510 with claim adjustment reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   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..."

   Review of the Centers for Medicare and Medicaid Services, National Correct Coding Initiative Edits found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, finds Procedure Code 64510 has a CCI conflict with Procedure Code 26055. A modifier is not allowed. The carrier's denial is supported.

   The carrier did not maintain the denial for Procedure Code 64718. Review of the explanation of benefits dated March 11, 2016 finds a payment in the amount of $877.90 was recommended. As the amount in dispute per the DWC060 for this code is $877.89, no additional payment can be recommended.

2. Pursuant to provisions of Rule 134.402(d) no additional payment 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Peggy Miller Medical Fee Dispute Resolution Officer	March 23, 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.