



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

TEXAS SURGICAL CENTER

Respondent Name

LM INSURANCE CORP

MFDR Tracking Number

M4-16-3483-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

JULY 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2016 Texas Ambulatory Surgical Center Fee Schedule."

Amount in Dispute: \$594.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per body of OP report supports only irrigation in documentation. No debridement done."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2016	Ambulatory Surgical Care CPT Code 11010-F3	\$594.04	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - X133-This charge was not reflected in the report as one of the procedures or services performed.
 - B12-Code description not listed.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.

Issues

Does the documentation support billing code 11010-F3? Is the requestor entitled to reimbursement for code 11010-F3?

Findings

According to the explanation of benefits, the respondent denied reimbursement for code 11010-F3 based upon "X133-This charge was not reflected in the report as one of the procedures or services performed."

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 codes 26746-F3 and 11010-F3. These codes are defined as:

- 26746 – Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each
- 11010 –Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues.
- Modifier F3-Left hand, 4th digit.

Based upon the submitted Operative Report, the documentation does not support removal of foreign material or debridement; therefore, the requestor did not support billing code 11010. As a result reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

Medical Fee Dispute Resolution Officer

08/04 /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.