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 Medical Center at Trophy Club

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-17-2061-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services."

Amount in Dispute: $4,635.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual argues no payment is due for code C1762 and no additional payment for code 93005-59."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10 – 12, 2016	C1762	$4,635.49	$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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing(g) errors which is needed for adjudication
   - 18 – Exact duplicate claim/service
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(H)
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions
- A09 –DWC Rule definition of implantables does not encompass biologicals; biologicals aren't paid as implantables per CH 134. DWC Rule & Medicare
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 420 – Supplemental payment
- 768 – Reimbursed per O/P fg at 130% separate reimbursement for implantables (including certification) was requested per Rule 134.403(G)

Issues

Are the insurance carrier's denials of payment supported?

Findings

The requestor indicates an amount of $0.01 for CPT 93005-59 on the submitted DWC060. This amount will not be considered in this review.

The requestor is seeking reimbursement for Code C1762 which the insurance carrier denied with codes that include "16 – Claim/service lacks information or has submission/billing errors" and "225-The submitted documentation does not support the service being billed." 28 TAC §134.403 (d) states in pertinent part for coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided. Medicare describes the disputed code C1762 as "Connective tissue, human" and is further defined as:

> These tissues include a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue. They are used to treat urinary incontinence resulting from hypermobility or Intrinsic Sphincter Deficiency (ISD), pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological anatomy.

This information is available on the CMS website at this link: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/complet-list-devicecats-opps.pdf

Review of the submitted documentation including the operative report does not support that the use of code C1762 corresponded with the above definition of C1762. The documented use from the operative report was for aiding in soft tissue healing and preventing adhesion formation in the tendons of the hand. Per the above Medicare policy code C1762 is intended for use in the urinary, pelvic or urological anatomy. Accordingly, the division finds that the insurance carrier's denial reason codes "16 – Claim/service lacks information or has submission/billing errors" and "225-The submitted documentation does not support the service being billed" are supported. The requestor's documentation does not support the procedure as billed under code C1762.No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 26, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.