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
WILLIAMSON SURGERY CENTER

Respondent Name
ASCENSION HEALTH

MFDR Tracking Number
M4-18-4379-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our total allowable for the entire claim is $13,636.52 with Implants, please reconsider our implants for payment according to our contract."

Amount in Dispute: $4,083.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is seeking additional reimbursement under code C1713 and Q4125. Requestor has provided an invoice for Q4125 in the amount of $4120.00. This matches its asserted cost for its reimbursement calculation. Requestor has provided two other invoices. The amounts on those do not match with its asserted cost for C1713. There is no explanation of how those invoices substantiate the cost of that billed item."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2018	Ambulatory Surgical Care Services (ASC) HCPCS Code C1713	$2,335.96	$0.00
	ASC Services for HCPCS Code Q4125	$1,747.04	$0.00
	ASC Cervices for Code 29806-RT	$0.00	$0.00
	ASC Services for Code 29826-RT	$0.00	$0.00
TOTAL		$4,083.00	$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, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §133.10, sets out the required health care provider billing procedures.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
   - 4915-The charge for the services presented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
   - 954-The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
   - 11-The recommended allowance for the supply was based on the attached invoice.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

1. What are the services in dispute?
2. What is the applicable fee guideline for the disputed services?
3. Is the respondent's denial of payment for HCPCS code C1713 supported?

Findings

1. On the disputed date of service the requestor billed $18,017.52 for CPT codes 29806-RT, 29826-RT, Q4125, and C1713. The respondent paid $9,553.52. Per the Table of Disputed Services, the requestor is only seeking medical fee dispute resolution for codes C1713 and Q4125.
2. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
3. The respondent denied reimbursement for HCPCS code C1713 and Q4125 based upon reason, "97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated," "954-The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance," "4915-The charge for the services presented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment," "P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable," and "11-The recommended allowance for the supply was based on the attached invoice."

   28 Texas Administrative Code §134.402(b) (6) states, "Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and

reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

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, including the following paragraphs."

HCPCS code C1713 is defined as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

HCPCS code Q4125 is defined as "ArthroFlex, per sq cm."

28 Texas Administrative Code §133.10(f)(1)(W) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1)The following data content or data elements are required for a complete professional or non-institutional medical bill related to Texas workers' compensation health care: (W) supplemental information (shaded portion of CMS-1500/field 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line." A review of the submitted medical bill finds the requestor did not indicate on fields 24d-24h a request for separate reimbursement for the implantables. Therefore, the respondent's denial is supported. As a result, the requestor is not due separate reimbursement for code C1713 and Q4125.

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

		8/27/2018
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 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.