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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DENTON SURGICARE

Respondent Name
CITY OF DALLAS

MFDR Tracking Number
M4-18-4426-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
JULY 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim be paid in accordance with the 2017 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $2,278.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation and review of the appropriate Medicare Fee Guidelines we found the bill was processed without consideration of separate implants in error. Due to this error the bill in question was processed at Medicare's geographically adjusted, fully implemented rate plus 235 percent which resulted in an overpayment on codes 23515 and 64418."

Response Submitted By: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 7, 2017	Ambulatory Surgical Care Services (ASC)	$2,278.00	$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. 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.
   - W3-Request for Reconsideration.
   - 18-Exact duplicate claim/service.
   - 247-A payment or denial has already been recommended for this service.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

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 $21,318.20 for CPT codes 23515-LT, 64418-LT-59, and C1713. The respondent paid $6,143.62. Per the Table of Disputed Services, the requestor is only seeking medical fee dispute resolution for code C1713.
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 based upon reason, "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(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)."

   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.

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

______________________	______________________	8/9/2018
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.