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 AT MANSFIELD

Respondent Name
LM INSURANCE CORP

MFDR Tracking Number
M4-19-4109-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2018 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $32,404.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "BAYLOR SURGICARE MANSFIELD was reimbursed at $27294.81. Provider did not request separate reimbursement on original billing [see attached]. Therefore, allowance was made at 235% based on locality and wage index for place of service."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2018	Ambulatory Surgical Care Services CPT Code C1767	$32,404.00	$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, effective May 31, 2012 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.
   - W3-Request for reconsideration or appeal.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

Is the requestor due reimbursement for HCPCS code C1767?

Findings

1. On the disputed date of service the requestor billed $44,841.00 for CPT code 63685, and $32,404.00 for code C1767. The respondent paid $27,294.81 for code 63685. Per the Table of Disputed Services, the requestor is only seeking medical fee dispute resolution for code C1767.
2. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
3. The respondent denied reimbursement for HCPCS code C1767 based upon reason, "97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated."
4. The respondent wrote, "Provider did not request separate reimbursement on original billing [see attached]. Therefore, allowance was made at 235% based on locality and wage index for place of service."
5. To determine if the denial of payment for HCPCS code C1767 is supported the division refers to the following statutes:
   - 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."
   - 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."
   - 28 Texas Administrative Code §134.402(g)(1)(B) states, "The facility or surgical implant provider requesting reimbursement for the implantable shall: (B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law

that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled."

6. HCPCS code C1767 is defined as "Generator, neurostimulator (implantable), nonrechargeable."
7. Based upon the review of the submitted documentation and above referenced statute, the division finds:
   - The requestor did not indicate on the medical bill on fields 24d-24h a request for separate reimbursement for the implantables as required by 28 Texas Administrative Code §133.10(f)(1)(W).
   - The requestor is not due separate reimbursement for HCPCS code C1713 due to billing errors.

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 reimbursement for the disputed services.

Authorized Signature

		06/07/2019
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 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. **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.