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
CORPUS CHRISTI OUTPATIENT SURGERY CENTER

Respondent Name
TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-21-1470-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
APRIL 22, 2021

REQUESTOR'S POSITION SUMMARY

"Creative Risk Funding has denied reimbursement for these billed HCPCS codes as it was not authorized and a reconsideration was sent followed by appeal as the Workers' Comp. carrier continued to deny payment, resulting for us to submit a Medical Fee Dispute."

Amount in Dispute: $2,808.04

RESPONDENT'S POSITION SUMMARY

"Surgery Center failed to bill its request for separate implants consistent with Rule 134.402(g)(1)(B) prior to January 26, 2021 in that it did not submit a copy of the implant certification with its medical bills sufficient to justify separate reimbursement in this claim."

Response Submitted By: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2020	Ambulatory Surgical Care Services (ASC) Code C1762	$2,145.00	$0.00
	ASC Services for Code C1713	$663.04	$0.00
TOTAL		$2,808.04	$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, of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 TAC §133.10, effective April 1, 2014, 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:
   - 150-Payer deems the information submitted does not support this level of service.
   - 16-Claim/service lacks information or has submission/billing error(s).
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - 284-Precertification/authorization/notification /pre-treatment number may be valid but does not apply to the billed services.
   - Medical billing diagnosis does not match Operative report. Surgery was for non-compensable diagnosis. CPT code was not authorized.
   - 284-This bill is considered a new bill due to original diagnosis codes changed/added/removed upon resubmission. Medical billing diagnosis does not match Operative report. Surgery was for non-compensable diagnosis. CPT code was not authorized.
   - W3-Reconsideration/Appeal.
   - HCPCS code was not authorized. Previous gross recommended payment amount on line $0.

Issues

Is the respondent's denial of payment for HCPCS codes C1762 and C1713 supported? Is the requestor due reimbursement for HCPCS codes C1762 and C1713?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,808.04 for HCPCS codes C1762 and C1713 rendered on July 21, 2020.

2. The respondent denied reimbursement for HCPCS codes C1762 and C1713 based upon "Medical billing diagnosis does not match Operative report. Surgery was for non-compensable diagnosis. CPT code was not authorized."

   28 TAC §133.307(d)(2)(H) requires the respondent to submit documentation "If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

   The respondent di d not submit any Plain Language Notice in accordance with §124.2 in accordance with 28 TAC §133.307(d)(2)(H) to support denial based upon relatedness. The DWC finds the respondent did not support the relatedness denial.

3. The respondent also denied reimbursement for HCPCS codes C1762 and C1713 based upon "197-Payment denied/reduced for absence of precertification/authorization," "284-Precertification/authorization/ notification /pre-treatment number may be valid but does not apply to the billed services," and "HCPCS code was not authorized. Previous gross recommended payment amount on line $0."

   The requestor did not submit the preauthorization report to support services were preauthorized. The DWC finds the denial of payment based upon "197," and "284" is supported.

4. The respondent also denied reimbursement for HCPCS codes C1762 and C1713 based upon billing error(s).

   28 TAC §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 requestor did not comply with 28 TAC §133.10(f)(1)(W).

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/23/2021
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 28 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 with the DWC. **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.