

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Grapevine Surgicare

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-21-2259-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

August 11, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 11, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 29827	\$0.00	\$0.00
	ASC HCPCS Code C1713	\$3,441.47	
	Total	\$3,441.47	\$0.00

*Typographical error on DWC-60 noted 29730 instead of 28730

Requestor's Position

"At this time we are requesting that this claim paid in accordance with the 2021 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: \$3,441.47

Respondent's Position

"The provider submitted an implant certification with the DWC60 packet however date signed and certified is not consistent with dispute date of service. The bill submitted shows only 1 unit for CPT code C1713 that totals \$3,148.00, the appeal letter from the provider is not clear as to which implants they are disputing. Payment for implants was made per supporting documentation (op report) received."

Response Submitted by: Texas Mutual Insurance Co.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, sets out the fee guidelines for ASC services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-131-Claim specific negotiated discount.
- DC3-Additional reimbursement allowed after reconsideration.
- 897-Separate reimbursement for implants made in accordance with DWC rule chapter 134; subchapter (E) health facility fees.

Issues

1. Is Grapevine Surgicare entitled to additional reimbursement for ASC services, HCPCS code C1713, rendered on February 11, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$3,441.47 for ASC services, HCPCS code C1713, rendered on February 11, 2021.

The respondent reimbursed the requestor \$880.00 based upon reason codes 225, CAC-16, CACP12, and 897. (description listed above)

The fee guidelines for disputed services is found in 28 TAC §134.402.

28 TAC §134.402(g)(1)(B) states,

A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable. (1) 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.

The DWC reviewed the submitted documentation and finds the implant cost certification was dated June 29, 2021. The submitted EOB indicates the carrier audited the bill on April 6, 2021. The requestor's certification is dated after this date. The DWC finds the requestor did not support that the implant cost certification was included with the initial billing as required by 28 TAC §134.402(g)(1)(B).

The DWC finds the requestor did not submit the implant record to support the implantables billed with HCPCS C1713; therefore, the respondent's denial of additional reimbursement based upon codes 225, CAC-16, CACP12, and 897 is supported.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

09/28/2021

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, **option 3 or email** CompConnection@tdi.texas.gov.