TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgicare at North Dallas

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-22-0361-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 22, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 5, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 26615	$0.00	$0.00
	ASC HCPCS Code C1713	$956.23	$0.00
	Total	$956.23	$0.00

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: $956.23

Respondent's Position

"Review of the bill confirms 1 unit was billed, and operative report submitted with the DWC60 confirms that only 3 screws are noted. Reimbursement is noted below: 3-1.5MMCORTEX SCREWS @$36.54 EA X 10% = $120.58."

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 ambulatory surgical care services.

Denial Reasons

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

- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- CAC-131-Claim specific negotiated discount.
- 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.
- 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- CAC-W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350-Bill has been identified as a request for reconsideration or appeal.
- 723-Supplemental reimbursement allowed after a reconsideration of services.
- 897-Separate reimbursement for implantables made in accordance with DWC rule Chapter 134; subchapter (E) health facility fees.

Issues

1. Is Texas Mutual Insurance Company's denial of payment or implantables based on a lack of information to support billing supported?

Findings

1. The requestor is seeking dispute resolution in the amount of $956.23 for the implantables HCPCS Code C1713 rendered on June 23, 2021.

   The requestor reduced payment for HCPCS code C1713 based upon reason codes, CAC-16, 225, and 892 (description listed above).

   28 TAC §134.402(b)(5) states "Implantable" means an object or device that is surgically:

   (A) implanted,

   (B) embedded,

   (C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program, and recharge the implantable."

A review of the submitted documentation finds the requestor submitted an invoice for $332.01, but did not submit a copy of the implant record to support which implants were billed with code C1713. The Operative report supports "[redacted] The respondent paid for three 1.5 mm cortex screws. The DWC finds the requestor did not support the amount sought; therefore, additional reimbursement is not recommended.

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	12/10/2021 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.