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 Plano

Respondent Name
Indemnity Insurance Co. of North America

MFDR Tracking Number
M4-22-1227-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
June 21, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 26, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 23410	$0.00	$0.00
	ASC CPT Code 17999	$0.00	$0.00
	ASC HCPCS Code C1763	$0.00	$0.00
	ASC HCPCS Code C1713	$1,842.50	$0.00
	Total	$1,842.50	$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: $1,842.50

Respondent's Position

"CorVel maintains implantable (HCPCS Code C1713) was reimbursed correctly in the amount of $880.00 based on the requestor's substantiated documentation."

Response Submitted by: CorVel

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:

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- W3-Appeal/Reconsideration.
- Provider requested separate reimbursement for implants. But failed to submit the certification stamp & MFG invoice for the cost of implant.
- 234-This procedure is not paid separately.
- RN1-Packaged service item; no separate payment made.

Issues

1. Is Baylor Surgicare at Plano entitled to additional reimbursement?

Findings

1. The requestor is seeking dispute resolution in the amount of $1,842.50 for the implantables HCPCS Code C1713 rendered on April 26, 2021.

   The respondent initially denied reimbursement for HCPCS codes C1713 based upon reason codes "234," and "RN1." Upon reconsideration the respondent paid $880.00 for code C1713 based upon the fee guideline.

   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 invoices but did not submit a copy of the implant record to support which implants were billed with codes C1763 and C1713; 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	03/22/2022 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.