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
Metrocrest Surgery Center LP

Respondent Name
Hartford Accident & Indemnity Co.

MFDR Tracking Number
M4-22-1595-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
March 31, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 11, 2021	Ambulatory Surgical Care Services, (ASC), CPT Code 28308-T6	$0.00	$0.00
	ASC CPT Code 28308-T7	$0.00	$0.00
	ASC CPT Code 64782-RT	$607.71	Not eligible for review
	ASC HCPCS Code 76000-TC	$0.00	$0.00
	ASC HCPCS Code C1713	$9,118.71	$0.00
	Total	$8,091.27	$0.00

Requestor's Position

"At this time we are requesting that this claim paid in accordance with the 2022 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $8,091.27

Respondent's Position

"The bill in question was received 11/25/21 and process 12/15/21...It was paid per fee and multiple procedure rules. There was a partial denial as bundled/included for the implants as

there was no request for separate reimbursement. Also, CPT 64782 was denied as unrelated per the PLN11 on file for extent of injury as the provider is using diagnosis of [redacted].

Response Submitted by: The Hartford

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.
3. 28 TAC §133.10, sets out the healthcare provider's billing procedures.
4. 28 Texas Administrative Code §141.1 sets out the procedure for requesting a Benefit Review Conference.
5. Texas Labor Code §408.021 sets out provisions regarding entitlement to medical benefits.
6. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.
7. Texas Labor Code Chapter 410 sets out provisions regarding adjudication of disputes.

Denial Reasons

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

- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 133-The disposition of this claim/service is pending further review.
- UNRL-Extent of injury not finally adjudicated. Reimbursement withheld-charge unrelated to compensable injury.
- 4915-The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 4458-Foresight-Charges for surgical implants are reviewed separately by Foresight Medical.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no

additional allowance appears to be warranted.

Issues

1. Is Hartford Accident & Indemnity Company's denial of payment for CPT code 64782 based on extent of injury supported?
2. Is Hartford Accident & Indemnity Company's denial of payment for HCPCS code C1713 based on separate reimbursement was not requested supported?

Findings

1. The requestor is seeking dispute resolution in the amount of $607.71 for CPT code 64782.

   The respondent denied reimbursement for CPT code 64782 based upon reason codes, "133," and UNRL." (description listed above)

   Dismissal

   28 Texas Administrative Code §133.305(b) requires that If a dispute regarding compensability, extent of injury, or liability exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, or liability shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §408.021 and Chapter 410.

   Upon review of the submitted information, the DWC finds the insurance carrier has denied payment for the health care for reasons related to the extent of injury or liability for the disputed services. The carrier's explanation of benefits was timely presented to the requestor in accordance with the requirements of 28 Texas Administrative Code §133.240.

   The DWC concludes there is an outstanding dispute regarding the extent of injury or liability for the disputed services. Consequently, the medical fee issues in dispute are not eligible for review until the related extent of injury or liability issues have been finally adjudicated in accordance with the provisions of Texas Labor Code Chapter 410.

   Notice

   The DWC hereby notifies the requestor that the process for resolving disputes regarding the extent of injury or liability for health care is found in Texas Labor Code Chapter 410 and corresponding DWC rules in 28 Texas Administrative Code Chapter 141.

   To resolve this matter, the requestor may file the required **Form DWC045**, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC), or to Proceed Directly to Contested Case Hearing (CCH)*
   with the field office handling the claim. A copy of Form DWC045 may be downloaded from the TDI-DWC website at www.tdi.texas.gov/forms/.

2. The requestor is seeking dispute resolution in the amount of $9,118.71 for the implantables with HCPCS code C1713.

The respondent denied reimbursement for HCPCS code C1713 based upon reason codes, "97," and "4915" and "P12." (description listed above)

The respondent wrote in the position summary that, "There was a partial denial as bundled/included for the implants as there was no request for separate reimbursement."

The fee guideline for ASC services is found in 28 TAC §134.402.

28 TAC §134.402(f)(2)(B) states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent.

28 TAC §134.402 (g)(1)(A) and (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:
> (A) bill for the implantable on the Medicare-specific billing form for ASCs;
> (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.

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."

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.

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. In addition, the implant cost certification was dated January 25, 2022. The original EOB indicates the carrier received the bill on November 25, 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 concludes the requestor did not comply with 28 TAC §134.402(g)(1)(B) and §133.10(f)(1)(W) for requesting separate reimbursement for implantables; therefore, the respondent's denial of payment for HCPCS code C1713 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 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	04/27/2022 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.