

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Surgicare at North  
Dallas

**Respondent Name**

Texas Mutual

**MFDR Tracking Number**

M4-22-1621-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

April 1, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 11, 2021	26951	\$0.00	\$0.00
June 11, 2021	15275	\$0.00	\$0.00
June 11, 2021	Q4104	\$2585.00	\$0.00
<b>Total</b>		<b>\$1158.94</b>	<b>\$0.00</b>

### 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."

**Amount in Dispute:** \$1158.94

### Respondent's Position

The Austin carrier representative for Texas Mutual is Texas Mutual. The representative was notified of this medical fee dispute on April 5, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available.

## **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 Texas Administrative Code (TAC) §133.307, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402 sets out the reimbursement guidelines for ambulatory surgical care services.

### Denial Reasons

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

- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- CAC-59 – Processed based on multiple or concurrent procedure rules
- D25 – Approved non network provider for Workwell, TX network claimant per Rule 1305.153(C)
- 618-The value of this procedure is packaged into the payment of other services performed on the same date of service
- 763-Paid per ASC FG at 235%: Implants not applicable or separate reimbursement (w/signed Cert) not requested: Rule 134.402(G).
- 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.
- W3 - In accordance with rule 34.804, this bill has been identified as a request for reconsideration or appeal.

### Issues

1. Did the requestor bill for the implant in accordance with Rule 134.402?

### Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$1158.94 for an implant provided as part of a surgery at an ambulatory surgical center on June 11, 2021.  
DWC Rule 28 TAC §133.10(f)(1)(W) states in pertinent part, 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 in fields 24d-24h a request for separate reimbursement for the implants. The requestor did not comply with 28 TAC §133.10(f)(1)(W).

Additionally, 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 code Q4104. No additional reimbursement is 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**

_____	_____	June 21, 2022
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 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](http://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](mailto: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, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).