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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-1997.01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 17, 2022	27726	$0.00	$0.00
January 17, 2022	20900	$0.00	$0.00
January 17, 2022	27612	$0.00	$0.00
January 17, 2022	76000	$0.00	$0.00
January 17, 2022	C1713	$5874.00	$0.00
	Total	$2773.08	$0.00

Requestor's Position

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

Amount in Dispute: $2,773.08

Respondent's Position

"The Austin carrier representative for Texas Mutual is Texas Mutual. The representative was notified of this medical fee dispute on May 17, 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 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 centers.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 59 – Processed based on multiple or concurrent procedure rules
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions

Issues

1. Is the insurance carriers' denial supported?

2. What rule applies for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking reimbursement of an implant provided as part of a surgical procedure rendered in an ambulatory surgical center in January 2022. The insurance carrier denied Code C1713 based on the current CPT code descriptions/instructions.

   DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   Review of the description of Code C1713 found, "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)". This code has a payment indicator of "N1" in the

applicable Addenda AA related to ASC covered services at www.cms.gov.

DWC Rule 28 TAC §134.402 (d) (1) states specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

DWC Rule 28 TAC §134.402 (f) states in pertinent part separate reimbursement for implants may be requested and paid per applicable DWC gee guideline. The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. Review of the "Operative Report" included with the request for MFDR found the implants listed are, AlloMatrix 1 ML bone graft and In2Bones ankle fibular plate. The report also indicates, "…I placed the plate over the fibula and secured with four screws distally and three screws proximally."

   DWC Rule 28 TAC §134.402 (2) (B) (i) states 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 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.

   The invoices submitted with the request for medical fee dispute lists several types of screws. The submitted medical bill indicates (1) unit. Insufficient evidence was found to support which of the (1) screws listed in the operative report the requestor is seeking reimbursement for. No additional payment 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

______________________	______________________	August 29, 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. 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, opción 3 o correo electronico CompConnection@tdi.texas.gov.