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
Ambulatory Eye Surgery Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-2448-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
July 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 23, 2022	65210	$500.99	$0.00
	Total	$500.00	$0.00

Requestor's Position

The requestor did not submit a position statement with their request for Medical Fee Dispute Resolution.

Amount in Dispute: $500.00

Respondent's Position

"Review of the bill and audit confirms procedure code 65210 has a status indicator N1 per ASC Addendums which means this procedure code is a packaged item, separate payment is not payable. ...Our position is that no payment is due."

Response submitted by: Texas Mutual

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 medical payment policy for ambulatory surgical center.

Denial Reasons

The insurance carrier denied the disputed service with the following claim adjustment codes.

- 662 – Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package.
- 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.

Issues

1. Is the requestor's position statement supported?

Findings

1. The requestor is seeking reimbursement of Code 65210 for date of service March 3, 2022. The insurance carrier denied the service based on the payment indicator assigned by Medicare payment policy.

   DWC Rule 28 TAC §134.402 (d) states in pertinent part, for coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided.

   Review of the assigned payment indicator in Addendum AA at www.cms.gov. indicates Code 65210 has a payment indicator of N1 which is defined as packaged service/item; no separate payment made.

   Based on the above, 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 22, 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.