TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Orthopedic and Spine Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-1739-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 16, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reconsider additional payment for Rev code 278/Implants which the expected reimbursement is $8.245.00."

Amount in Dispute: $8,245.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position for the denial of the implants, the facility did not provide a certification for billing implants. All billing records, appeal and DWC60 packet has been confirmed, that the certification was not received."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2019	Outpatient Hospital Services	$8,245.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 16 – Claim/service lacks information or has submission/billing error(s).
   - D25 – Approved non network provider for Workwell, Tx Network

- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 768 – Reimbursed per O/P FG at 130%. Separate reimbursement for implantables (including certification was requested per Rule 134.403(G)
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $8,245.60 for reimbursement of implants during an outpatient hospital service rendered on September 10, 2019

   The insurance carrier states, "According to research the provider has not fully complied with TAC Rule 134.403 (g)(1)."

   Review of the submitted documentation found insufficient evidence to support the requirements for 28 TAC 134.403(g)(1) or a facility or surgical implant provider billing separately for an implantable shall 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."

   The insurance carrier's position is supported. As the implants are the only disputed charges on the requestor's DWC-60, no additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute

Authorized Signature

		April 7, 2020
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.