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 & Spine Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-2721-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reconsider additional payment for Rev code 278/Implants which separate reimbursement was requested in Box 80 of UB-04 form."

Amount in Dispute: $5,284.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual issued payment in the amount of $27,588.33... An appeal was received, according to the appeal letter the provider is requesting additional payment for the implants in the amount of $13,917.02 of which $7164.03 was owed. The auditor reviewed the bill and made a supplemental payment for tibial tray, pins, screws and stem inbone talar in the amount of $1868.11. ...Payment should have been 108% per request for implant reimbursement. Payment on the initial submission should have been for $20,835.94."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2019	Inpatient Hospital Services	$5,284.16	$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 §134.404 sets out the fee guideline for hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 305 – The implant is included in this bill and is reimbursed at the higher percentage calculation
- 897 – Separate reimbursement for implantables made in accordance with DWC rule chapter 134. Subchapter E health facility fees.

Issues

Is the requestors position supported?

Findings

The requestor is seeking reimbursement of $5,284.16 for implants administered during an inpatient hospital service in October of 2019.

28 TAC 134.404 (g) (1) states implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at 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 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 costs (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."

Review of the submitted documentation found no invoices to support the requested amount nor was the certification of the cost included with the submitted documentation.

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

Signature	Medical Fee Dispute Resolution Officer	August 6, 2020 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.