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
M4-20-3024-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 31, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the EOB partial payment has been made indicating that the payment for implants have been disallowed. Enclosed document EOB Medical Note Implant Invoices Implant Log."

Amount in Dispute: $7,561.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted DWC060 absent Implant Certification."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 10, 2019	Rev 278 - Implants	$7,561.43	$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:
    - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
    - 892 – Denied in accordance with DWC rules and/or medical fee guidelines including current CPT code
    - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 225 – The submitted documentation does not support the service being billed. We re-evaluate this upon receipt of clarifying information
- 770 – Implant provider charges denied per outpatient require certification not included or was requested per Rule 134.403(G)

Issues

Is the denial of the implants supported per Rule?

Findings

The requestor is seeking reimbursement in the amount $7,561.43 for implants utilized in an outpatient procedure rendered on December 10, 2019. The insurance carrier denied the service as required documentation not provided.

The requestor stated, “supporting documentation is also attached” in their position statement. Insufficient evidence was found to support the requirements of 28 TAC §134.403 (g) (1) which states in pertinent part, 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."

Based on this lack of invoices and certification statement, the insurance carrier’s denial is supported. 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	October 5, 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.