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 CO

MFDR Tracking Number
M4-21-0717-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
DECEMBER 28, 2020

REQUESTOR'S POSITION SUMMARY

"Rev code 278 for implants was not paid. Please note that separate reimbursement was requested in box 80 of UB04. Implant Invoice is also attached for review. In accordance with the TX WC fee schedule implants should be paid at manual cost + 10%"

Amount in Dispute: $21,277.34

RESPONDENT'S POSITION SUMMARY

"Texas Mutual elects to reprocess bill for additional payment on the implants. It is confirmed that the facility did submit the original implant certification with the initial billing on 2/17/20. It is also confirmed that the implant invoice and purchase order was received on appeal."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2020	HCPCS Code C1713	$21,277.34	$2,639.03

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403, effective March 1, 2008, sets out the reimbursement guidelines for outpatient hospital services.

3. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - CAC-16-Claim/service lacks information which is needed for adjudication.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - CAC-18-Exact duplicate claim/service.
   - DC4-No additional reimbursement allowed after reconsideration.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - DC7-Duplicate appeal. Network contract applied by Workwell, TX.
   - 350-In accordance with TDI-DWC rule 234.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor due additional reimbursement for HCPCS code C1713 rendered on January 28, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $21,277.34 for HCPCS code C1713 rendered on January 28, 2020.
2. The respondent wrote, "Texas Mutual elects to reprocess bill for additional payment on the implants." At the time of this review, the respondent had not submitted payment information to support the dispute had been resolved; therefore, the DWC will review in accordance with the fee guideline.
3. The fee guideline for hospital outpatient services is found at 28 TAC §134.403.

   The requestor sought separate reimbursement for the implantables; therefore, 28 TAC §134.403(g) applies to this dispute.

   28 TAC §134.403(g) 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.

4. HCPCS Code C1713

   HCPCS code C1713 is defined as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

5. The following Table reflects the DWC findings:

Implant Log	Units	Cost	MAR
A4856.43	1	$1,334.48	$1,467.93
A5800.1611	2	$179.52	$394.94
A5800.1811	1	$89.76	$98.74
A5850.2211	2	$145.44	$319.97
A5800.1211	1	$145.44	$159.98
A5800.1411	1	$89.76	$98.74
A5850.1211	1	$89.76	$98.74
Total Due			$2,639.03

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,639.03.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $2,639.03, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

		02/02/2021
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 28 Texas Administrative Code §133.307, 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 the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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