TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Orthopedic & Spine Hosp

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-21-0935-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 5, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB expected reimbursement for implants was partially."

Amount in Dispute: $4,689.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to the documentation submitted, Baylor Ortho and Spine Hospital confirms 2 implantable devices. Audit staff review the documentation purchase order submitted and paid the implantable devices accordingly."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2020	C1713	$4,689.43	$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 guidelines for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
   - 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service

- 764 –
- 896 – Separate reimbursement for implantables made in accordance with DWC rule Chapter 134, subchapter (E) health facility fees

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking additional reimbursement of implants rendered during an outpatient hospital procedure on February 12, 2020. The insurance carrier states in their position statement that two implantable devices were supported by the documentation and the other billed implants were inclusive to the procedure.

Review of the submitted documentation found the submitted medical bill indicates eight units billed under revenue code 278, HCPCS code C1713.

Review of the submitted documentation found on page six of twelve of the "Perioperative Record", under implant log three entries were made. However, the "Surgical Documentation" does not identify any implants used during the procedure.

DWC Rule 134.403 (b) (2) defines an implant as an object or device that is surgically implanted, embedded or inserted, or otherwise applied. The submitted documentation does not support how the disputed services met this requirement. No 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

		March 8, 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 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.