TDI Division of Workers' Compensation
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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
M4-21-2403-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
August 24, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 16, 2021	C1713	$407.00	$407.00
March 16, 2021	C1781	$2860.00	$2860.00
	Total	$3,267.00	$3,267.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Please reconsider additional payment for CPT code C1713 and C1781 which was denied for payment due to service considered to be an experimental/investigational, and preauthorization required. Please note that treatment provided was reasonable and necessary, and implants should be paid at manual cost plus 10%."

Amount in Dispute: $3,267.00

Respondent's Position

Review of the audit confirms that CPT code C1713 was paid $4065.60 – Per DWC60 and position statement healthcare provider is disputing payment for $407.00 however does not elaborate or include supporting documentation for the additional payment. Implants for C1713 were paid according to invoices submitted.

CPT code C1781 – mesh implant, biological implants are not included in the definition as an object or device implant per Rule 134.403(b)(2). Audit staff denied the bill with A09 message code indicating it is a biological. Preauthorization was not specifically obtained for the Mesh, per ODG Mesh is considered experimental.

Response Submitted by: Texas Mutual

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.
3. 28 TAC §137.100 sets out the administrative process for retrospective review.
4. 28 TAC §19.2003 defines retrospective review.
5. 28 TAC §19.2015 sets out the requirements for notification of utilization review.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- A09 – DWC Rule 134.403(B)(2) & Medicare by definition of implantables does not encompass biologicals
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- 198 – Precertification/authorization exceeded
- 55 – Procedure/treatment is deemed experimental/investigational by the payer
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 769 – Service not included in an/or exceeds preauthorization approval
- 761 – Service considered experimental and/or investigational therefore preauthorization is required.

Issues

1. Is the insurance carriers' denial supported?

2. What rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier denied the payment of Code C1781 – Mesh (implantable). The insurance carrier states in their position statement the definition of an implantable not met per DWC and Medicare rules. Insufficient evidence was found to support the respondent's position.

   Additionally, the respondent states prior authorization was not obtained as the ODG considers Mesh as experimental. Insufficient evidence was found to support this position.

   The division notes that 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states:

   "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective review is defined in 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary."

   DWC Rule 28 TAC §19.2015(b) titled Retrospective Review of Medical Necessity states: (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)."

   The division finds that the carrier failed to follow the appropriate administrative process to address the assertions made in its response to this medical fee dispute.

2. DWC Rule 28 TAC 134.403 (g) 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.

   The submitted implants for the disputed services and are reviewed as follows:

   - "Anchors Bone 3 w arthro" as identified in the itemized statement and labeled on the invoice as "Anchors Bone w arthro" with a cost per unit of $800.00;

   - "Staple Tendon arthroscope" as identified in the itemized statement and labeled on the invoice as "Staple Tendon" with a cost per unit of $600.00;

- "Suture Anchor biocomposi" as identified in the itemized statement and labeled on the invoice as "Suture Anchor biocomposi" with a cost per unit of $417.00 at 3 units, for a total cost of $1,251.00;
- "Kit Proximal tenodesis" as identified in the itemized statement and labeled on the invoice as "Kit Proximal tenodesis" with a cost per unit of $675.00;
- "Fibertak RC Double-loaded" as identified in the itemized statement and labeled on the invoice as "Fibertak RC Double-loaded" with a cost per unit of $370.00;
- "Fibertak RC Double-loaded" as identified in the itemized statement and labeled on the invoice as "Fibertak RC Double-loaded" with a cost per unit of $370.00;
- "Implant Mesh Bioinductive" as identified in the itemized statement and labeled on the invoice as "Implant Mesh" with a cost per unit of $2,600.00.
- The total net invoice amount (exclusive of rebates and discounts) is $6,666.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $666.60. The total recommended reimbursement amount for the implantable items is $7,332.60.

3. The total recommended reimbursement for the disputed services is $15,271.31. The insurance carrier paid $12,004.31. The amount due is $3,267.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $3,267.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is [not] entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual must remit to Baylor Orthopedic & Spine Hospital $3,267.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 11, 2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

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

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.