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
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-22-0020-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
September 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 19, 2021	Implants	$24,518.79	$0.00
	Total	$24,518.79	$0.00

Requestor's Position

Requestor did not submit a position statement but did submit a copy of their reconsideration request that states, "Per TX workers compensation guidelines implants should be reimbursed at manual cost plus 10% which implant invoices are enclosed for review."

Amount in Dispute: $24,518.79

Respondent's Position

The records submitted support 5 implants and 1 supply. The billing reflects 6 implants, however, one item billed as an implant is really a supply (Kit). This was the vis kit that is used to get an exact cut of the bone. This would not be paid as an Implant.

Response Submitted by: Liberty 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 §134.404 sets out the fee guidelines for inpatient hospital services with implants

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup
- 11 – The recommended allowance for the supply was based on the attached invoice
- 8 – The supply charge was disallowed as it was not adequately identified

Issues

1. Is the insurance carriers' denial supported?

Findings

1. The requestor is seeking additional reimbursement for implants of a surgery done as an inpatient hospital visit in February 2021.

   The insurance carrier reduced the amount reimbursed based on lack of supporting documentation. 28 TAC §134.404(g)(1) requires providers to include a certification of the actual cost of the implantable.

   Review of submitted documentation found all items billed under revenue code 278 were not supported by invoices showing the cost of each item. The insurance carrier's reduction is supported. No additional reimbursement 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 not established that additional reimbursement 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.

Authorized Signature

		September 28, 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 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.