TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital At
TR

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-22-0328-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
October 16, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 27, 2021	C1713	No amount on DWC060	$0.00
April 27, 2021	C1762	No amount on DWC060	$0.00
April 27, 2021	L8699	No amount on DWC060	$0.00
April 27, 2021	23420	No amount on DWC060	$0.00
	Total	$1663.18	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "According to TX workers compensation guidelines implants should be reimbursed at manual cost plus 10% which the expected reimbursement for C1713 is $1,127.59."

Amount in Dispute: $1663.18

Respondent's Position

The bill has been reviewed and adjusted for payment – copies of EOBs are submitted for your review

Response Submitted by: Liberty Mutual Insurance

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 [description].

Denial Reasons

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

- W3 – Additional payment made on appeal/reconsideration
- 4915 – The charge for the services represented by the code is include/bundled into the total facility payment and does not warrant a separate payment or the payment or the payment status indicator determines the service is packaged or excluded from payment
- 905 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor), component code of comprehensive pathology/laboratory service procedure (80000 – 89999) has been disallowed

Issues

1. Did the requestor submit required documentation to support additional payment?

Findings

1. The requestor listed Codes C1713, C1762 and L8699 on the medical bill which are all codes for implants. A separate request for implant reimbursement was made.

   DWC Rule 28 TAC §134.403 (g) states in pertinent part implantables shall be reimbursed the lesser of the manufacturer's invoice amount or the net amount 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.

   Review of the submitted documentation found insufficient evidence to support the invoice amount for the disputed implants. No additional payment 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

Signature	Medical Fee Dispute Resolution Officer	January 10, 2022 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.