TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Hermann Specialty Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0959-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 5, 2021	C1713	$3527.15	$3527.15
August 5, 2021	C1762	$1237.50	$1237.50
	Total	$4,764.65	$4,764.65

Requestor's Position

Requestor did not submit a position statement but submit a copy of their reconsideration that states, "Please note that implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $9,583.46 leaving a balance of $4,846.15."

Amount in Dispute: $4,764.65

Respondent's Position

...The implant payment paid by Texas Mutual was issued in error. ...Morphus bone graft C1762 – was denied as it considered a biological per rule 134.403(b)(2).

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.

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 bilogicals
- Please submit invoice for Arthrex tightrope implant

Issues

1. Is the insurance carrier denial for lack of invoice supported?

2. Is the insurance carrier's denial for definition of implant supported?

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

4. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier denied the implant "TightRope XP" for lack of invoice. Review of the submitted documentation found invoice number 912639312 dated August 4, 2021. The insurance carrier's denial is not supported. The disputed implant charge will be reviewed per applicable fee guidelines.
2. The insurance states the Morpheus, Volume 3cc does not meet the definition of an implanted per DWC Rule 134.403 (b) (2) or Implantable" means an object or device that is surgically:

   (A) implanted,

   (B) embedded,

   (C) inserted,

   (D) or otherwise applied, and

   (E) related equipment necessary to operate, program and recharge the implantable.

Review of the FDA Product Code at 3cc Morpheus Medical Device Identification (fda.report) define this product as, "Filter, Bone Void, Calcium Compound, Resobable Calcium Void Filter Device.

The insurance carrier's denial is not supported. The disputed implant charge will be reviewed per applicable fee guidelines.

3. DWC Rule 28 TAC §134.403 (g) states in pertinent part, 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 total net invoice amount (exclusive of rebates and discounts) is $5,668.00. 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 $566.80. The total recommended reimbursement amount for the implantable items is $6,234.80.

4. The total recommended reimbursement for the disputed services is $6,234.80. The insurance carrier paid $1,470.15. The requestor is seeking additional reimbursement of $4,764.65. 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 $4,764.65 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Co must remit toMemorial Hermann Specialty Hospital $4,764.65 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	March 30, 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.