



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-22-1431-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

March 14, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 24, 2021	C1713	\$715.00	\$0..00
September 24,, 2021	L8699	\$7,150.00	\$7,150.00
	Total	\$7,865.00	\$7,150.00

Requestor's Position

Requestor did not submit a position statement but submit a copy of their reconsideration that states, "Please note that separate reimbursement was requested in Box 80 UB-04 form for implants and implant invoices are enclosed for review."

Amount in Dispute: \$7,865.00

Respondent's Position

Review of the audit confirms 2.6mm reamers were not paid as implants. Op report supports 2 cuts fitted for 6mm implants to fill in space. Texas mutual maintains the denial for L8699 – Fresh frozen talus allograft for reconstruction of joint is considered a biologic, therefore A09 denial

reason code is applicable per Rule 134.403(b).

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 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
- 16 – Claim/service lacks information or has submission/billing errors which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 270 – The hospital outpatient allowance was calculated according to the APC rate plus a markup
- 768 – Reimbursed per O/P at 130%. Separate reimbursement for implantables (including certification) was requested per Rule 134.403(G)
- 892 – Denied in accordance with DWC Rules and/or Medical Fee Guideline including current CPT code descriptions/instructions

Issues

1. Is the insurance carrier's position statement supported?
2. What rule applies for determining reimbursement for the disputed services?

Findings

1. The insurance carrier denied the implants billed under HCPCS code C1713 as lacking information. Review of the submitted medical record versus the itemized bill shows no indication of "Anchor" on the submitted invoices or "Final Report." The insurance carrier's denial is supported.

The insurance carrier also states the remaining implant (Allograft) does not meet the definition of an implant per Medicare and DWC Rule 134.403 (2) states "Implantable" means an object or device that is surgically:

- (A) implanted,
- (B) embedded,
- (C) inserted,
- (D) or otherwise applied

Review of the "Final Report" indicates, "I then obtained the allograft talus on the back table. I drilled out two 6mm plugs and then cut them to the correct length. I then placed the plugs within the pe-formed cavity."

Sufficient documentation to support the "Allograft Talus Fresh" was implanted and supported by applicable invoices for the cost.

The insurance carrier's denial based on biologics not considered an implant is not evident in the applicable DWC Rule or Medicare payment policy. The disputed charge will be considered per fee guideline.

2. DWC Rule 28 TAC 134.403 (g) states, 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 "allograft talus fresh" as identified in the itemized statement and labeled on the invoice as "Talus fs/a rt" with a cost per unit of \$6,500.00. 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 \$650.00. The total recommended reimbursement amount for the implantable item is \$7,150.00.

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 requestor has established that additional reimbursement of \$7,150.00 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 respondent must remit to requestor \$\$7,150.00 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

April 13, 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 electrónico CompConnection@tdi.texas.gov.