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
M4-22-1889-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 6, 2021	C1713	$644.77	$0.00
August 6, 2021	C1781	$2,860.00	$1,087.12
	Total	$3,504.77	$1,087.12

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "According to TX Mutual workers compensation fee schedule the expected reimbursement for DOS 8/06/2021 is $14,812.64."

Amount in Dispute: $3,504.77

Respondent's Position

"Total payment for implants of the hardware $1731.40. C1781 continue to deny as a biological for the mesh, as it is not considered an object per Rule 134.403."

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:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- P12 - Worke's' compensation jurisdictional fee schedule adjustment
- A09 – DWC Rule 134.403(B)(20 & Medicare by definition of impantables does not encompass implantables
- 18 – Exact duplicate claim/service
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 350 – In accordance with the DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 370 – this hospital outpatient allowance was calculated according to the APC rate plus a markup
- 768 – Reimbursed per O/P fg at 130% separate reimbursement for implantables (including certification) was requested per Rule 134.403(G)

Issues

1. Is the insurance carrier's denial supported?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of implants utilized during an outpatient hospital surgery in August 2021. The insurance carrier denied Code 1781 as not meeting the definition of implant per DWC rule 134.403. Insufficient evidence was presented by the insurance carrier in support of their denial. The disputed service will be reviewed per applicable fee guideline.
2. DWC Rule 28 TAC §134.403 (g) states in pertinent part, when implantables are 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.. Review of the submitted documents included with the request for MFDR found invoices to support the cost of the Staple Tendon Arthroscope, Bone Anchors and Implant Mesh. The other products billed under revenue code 278 only had documents titled "Bosha Materials Storage" to support cost. Only those products supported by invoices will be reviewed for reimbursement under applicable fee guidelilne. The applicable fee guideline is as follows.
    - "Staple Tendon Arthroscope 2504-1" as identified in the itemized statement and labeled on the invoice as "Tendon anchors" with a cost per unit of $600.00;
    - "Anchors Bone 3 W artho Smith & Nephew 2067279" as identified in the itemized statement and labeled on the invoice as "Bone Anchors 3 2 arthro" with a cost per unit of $800.00;
    - "Implant Mesh Bioinductive System 4565" as identified in the itemized statement and labeled on the invoice as "Implant Mesh Bioinductive " with a cost per unit of $2,600.00.

    The total net invoice amount (exclusive of rebates and discounts) is $4,000.00. 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 $400.00. The total recommended reimbursement amount for the implantable items is $4,400.00.
3. The total recommended reimbursement for the disputed services is $12,401.25. The insurance carrier paid $11,314.13. The amount due is $1,087.12. 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 $1,087.12 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 must remit to Baylor Orthopedic and Spine Hospital $1,087.12 plus applicable accrued interest within 30

days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 25, 2022
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.