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 Orthopedic & Spine Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-2079-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 20, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 30, 2021	C1762	$4,208.11	$0.00
September 30, 2021	C9359	$3,371.50	$0.00
	Total	$7,579.61	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Please note that implants should be reimbursed at manual cost plus 10% which were partially paid."

Amount in Dispute: $7,679.61

Respondent's Position

"Texas Mutual paid the bill per Rule 134.203(d)(1)... Our position is that no payment is due."

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
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdicational fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Is the requestor's denial of implants 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 for implants that were billed with Code C1762 – Connective tissue, and code C9359 – Porous purified collagen matrix bone void filler. The insurance carrier denied these claim lines as being packaged into other APC codes.

   Review of the the CMS OPPS Addenda B finds both of these codes have a status indicator of "N" which does mean the service is packaged. However, DWC Rule §134.403(d)(1) states in pertinent part, "For coding, billing reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies… Specific provisions contained in the Texas Labor Code or the Texas Department of

Insurance, Division of Workers' Compensation (Division) rules, shall take precedence over any conflicting provision adopted or utilized by CMS in Administration of the Medicare program. DWC Rule §134.403 (g) allows for the request for separate reimbursement of implants. The insurance carrier's denial is not supported.

2. DWC Rule 28 TAC §134.403 (g) states in pertinent part, implantables billed separately by the facility shall be reimbursed at the lesser of the manufacturer's invoice 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. The requestor submitted the following line items supported by an itemized statement.
    - C1713/Custom Device F&A Low Co (1) unit, $11995.00. Cost supported by invoice.
    - C1713/Screw Dynanail Mini Head, (1) unit $625. Cost supported by invoice.
    - C1713/Screw Dynanall Mini Head, (1) unit $6295.00. Cost **NOT** supported by invoice.
    - C1713/Nail Mini 7mm x 60mm 260 (1) unit $6295.00. Cost **NOT** supported by invoice.
    - C1713/Guidewire, 2.4mm Medshape (1) unit $235.00. Cost supported by invoice.
    - C1713/Pin Steinmen 2.0mm (2) units, $470. Cost supported by invoice.
    - C1762/Kit Bone Graft sm 2.8cc (1) unit $3825.55. Cost **NOT** supported by invoice.
    - C9359/Trinity elite 5cc med (1) unit $3065.00. Cost supported by invoice.

    The total of implants that met the definition of DWC Rule §134.403 (g) is $16,390.00 with a invoice amount plus 10 percent or $1,000 per billed item add-on whichever is less equals $17,829.50 (16,390.00 + $1,439.50).
3. The total recommended reimbursement for the disputed services is $17,829.50. The insurance carrier paid $31,077.60. 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	June 28, 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.