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
M4-22-2328-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
June 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 29, 2021	C1713	$3,632.22	$0.00
	Total	$3,632.22	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $3,632.22

Respondent's Position

"…Texas Mutual believes the provider submitted DWC60 prematurely. The facility submitted a bill to Texas Mutual for processing on 6/29/2022 for DOS 9/29/2021. The bill at this time is still pending, final adjudication of the bill has not been determined."

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 requirements of outpatient hospital billing.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 – Workers' Compensation Jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 768 – Reimbursed per O/P FG at 130% separate reimbursement for implantable (including certification) was requested per Rule 134.403 (G)
- 897 – Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134; Subchapter (E) Health Facility fees

Issues

1. Did the requestor support their request for additional reimbursement of implants?

Findings

1. The requestor is seeking additional reimbursement of implants provided as part of an outpatient hospital surgery in September 2021. Review of the submitted documentation found the insurance carrier paid $880.00 upon reconsideration yet, the requestor seeks additional reimbursement.

   DWC Rule 134.403 (g)(1) 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.

   A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

The documentation included with this request for medical fee dispute resolution (MFDR) did not include manufacturer's invoice(s) or the required billing certification. No additional reimbursement 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	December 8, 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.