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
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-22-2366-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
July 6, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 19, 2021	C1713	$319.05	$0.00
	Total	$319.05	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Please reconsider additional payment for CPT code C1713/implants which was partially paid. Implants should be reimbursed at manual cost plus 10% which the expected reimbursement for C1713 is $2,679.93. Previous payment received totaled $14,135.19 leaving a balance of $319.05."

Amount in Dispute: $319.05

Respondent's Position

The Austin carrier representative for TASB Risk Management Fund is Burns Anderson Jury & Brenner. The representative was notified of this medical fee dispute on July 11, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- 353 – This charge was reviewed per the attached invoice.
- 350 – Bill has been identified as a request for reconsideration or appeal.

Issues

1. What rule applies for determining reimbursement for the implants?

Findings

1. The requestor is seeking additional payment for an implant provided during an outpatient hospital surgical procedure.

   DWC Rule 28 TAC §134.403 (g) (1) states in pertinent part, 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."

   Review of the submitted documentation included with the request for MFDR found insufficient evidence to support the required certification of cost was made by the requestor.

   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

		August 15, 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.