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
M4-23-0308-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 5, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 05, 2022	Hospital Outpatient	$4,625.13	$0.00

Requestor's Position

According to TX Workers compensation fee schedule the expected reimbursement for DOS 4/05/2022 is $15,513.45. Please note that implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $10,888.32 leaving a balance of $4,625.13. Please reprocess and remit payment for remaining balance due.

C1713-$7,420.82

25390-UB TX O/P APC: 6,225.10 x 130%=$8,092.63.

Amount in Dispute: $4,625.13

Respondent's Position

Texas Mutual has reviewed the DWC-60 submitted by BAYLOR ORTHO AND SPINE HOSPITAL.

On 4/22/22 Texas Mutual received a bill for a surgery with requested reimbursement of implants. We reimbursed BAYLOR ORTHO AND SPINE HOSPITAL per the following rules 134.403;

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection

(g) of this section, win which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent …

Total implants $2795.69

Our position is that no payment is due

Response Submitted by: Texas Mutual Workers Compensation Insurance

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 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

The insurance carrier reduced 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 – Workers' compensation jurisdictional fee schedule adjustment. Usage: if adjustment is at the claim level the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 REF). If adjustment is at the Line Level the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 REF) if the regulations apply. To be used for Workers' Compensation only

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. Review of the disputed services finds the requestor is seeking reimbursement for date of service

April 05, 2022 Code C1713 in the amount of $4,625.13.

28 Texas Administrative Code §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.

(1) 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 provided by the requestor finds no billing certification for the implants in dispute in accordance with 28 Texas Administrative Code §134.403 (g)(1). Therefore, no 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 15, 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.