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
Crescent Medical Center

Respondent Name
Transcontinental Insurance Co

MFDR Tracking Number
M4-23-1212-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
January 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
Febvruary 28, 2022	REV 0278 Implants	$2090.00	$2090.00
Febvruary 28, 2022	CPT 22830	UNKNOWN	$0.00
Febvruary 28, 2022	CPT 22850	UNKNOWN	$0.00
Febvruary 28, 2022	ALL OTHER	0.00	$0.00
	Total	$2090.00	$2090.00

Requestor's Position

The requestor did not submit a position statement with their request for reconsideration but did submit a copy of their reconsideration request that states, "The surgery codes themselves were not paid and the implants should be reimbursable as well."

Amount in Dispute: $2090.00

Respondent's Position

"Carrier has paid the appropriate Fee Guideline amount of $457.36 and no further allowable is due for C1713 as they are bundled services. Therefore, for the reasons noted above, reimbursement is notrecommended for the disputed service for C1713(0278).

Response submitted by: Law Office of Brian J. Judis

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 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 798 – Service is only reimbursed on an impatient basis
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Did the requestor support the cost of implants per applicable rule?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of implants rendered as part of an outpatient hospital surgery in February 2022. The insurance carrier denied the implants as being includeded in the payment/allowance of another service.

   DWC Rule 28 TAC §134.403 (g)(2) 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.

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B) of this title.

Review of the December 16, 2022 request for reconsideration included a request for implants and the DWC060 includes a request for separate reimbursement for implants. The applicable fee guideline is shown below.

2. DWC Rule 28 TAC §134.403 (g) 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.

   The Code C1713 – Anchor/screw bn/bn/tis/bn is identified on the itemized statement and labeled on the invoice as "Reficio DBM Crunch, 10cc" with a cost per unit of $950.00 at 2 units, for a total cost of $1,900.00.

   The total net invoice amount (exclusive of rebates and discounts) is $1,900.00. 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 $190.00. The total recommended reimbursement amount for the implantable items is $2,090.00.

3. The total recommended reimbursement for the disputed services is $2090.00. 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 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 respondent must remit to requestor $2090.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 10, 2023 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.