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
Texas Spine and Joint Hospital

Respondent Name
Luba Casualty Insurance Co

MFDR Tracking Number
M4-23-1272-01

Carrier's Austin Representative
Box Number 53

DWC Date Received
February 1, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 29, 2022	0250	$0.00	$0.00
August 29, 2022	0258	$0.00	$0.00
August 29, 2022	0270	$0.00	$0.00
August 29, 2022	0271	$0.00	$0.00
August 29, 2022	0272	$0.00	$0.00
August 29, 2022	0278	$2732.00	$0.00
August 29, 2022	0300	$0.00	$0.00
August 29, 2022	0360	$0.00	$0.00
August 29, 2022	0370	$0.00	$0.00
August 29, 2022	0710	$0.00	$0.00
August 29, 2022	0761	$0.00	$0.00
	Total	$2,732.00	$0.00

Requestor's Position

"However, our position is the enclosed invoice from Smith & Nephew, Invoice Number 943782190, accurately reflects the implant whose payment was denied by the Carrier, and is eligible for reimbursement under the fee guidelines."

Amount in Dispute: $2,732.00

Respondent's Position

"Carrier responds that the medical bills were properly denied based on the reasons provided on its initial EOB. The implant documentation has not been provided. Provider attached the patient account detail showing that 2.00 implants were provided. The attached invoices from Provider do not match up the quantities or descriptions of the billed implants. Carrier properly denied the bill based on no attachment / certified invoice."

Response submitted by: Hoffman Kelley Lopez

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:

- 252 – An attachment/other documentation is required to adjudicate this claim/inservice
- 253 – In order to review this charge please submit a copy of the certified invoice
- M12 – Missing patient medical record for this service

Issues

1. Is the disputed service eligible for reimbursement?

Findings

1. The requestor is seeking reimbursement of an implant listed on the patient account detail as "Implant Multifix 5.5 mm Peek Knotle." The implant sheet included with the documentation indicates "Knotless Suture Anchor" x 2 REF (illegible).

   Review of the operative report indicates, "I cleared the superficial cortex and then placed 2 Smith & Nephew helical anchors at the articular margin."

   The insurance carrier allowed payment of $759 for the implants listed as "Implant S&N Healicoli Sut Anch Ultr. Billed amount $1314.00 and $1283.00 each with a supported cost of $345.00 each.

The maximum allowable reimbursement is calculated as $345.00 x 10 per cent x 2 = $759.00.

The DWC finds the operative report indicates only two anchors were implanted during the procedure. Two anchors were paid by the carrier.

No additional payment is recommended.

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

		March 15,2023
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.