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 Surgical Hospital at TR

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-23-1274-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
February 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 8, 2022	C1713	$2,408,63	$0.00
February 8, 2022	C1781	$437.69	$0.00
	Total	$2,846.32	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of a document titled "Reconsideration" that states, "According to TX workers compensation fee schedule the expected reimbursement for DOS 2/08/2022 is $7,435.43. Please note that the implants should be reimbursed at manual cost plus 10%, and surgical code should be reimbursed at 130% Medicare rate. Previous payment received totaled $6,802.52 leaving a balance of $632.91."

Amount in Dispute: $2,846.32

Respondent's Position

"Therefore, in conclusion, ForeSight is disagreeing with the provider that an additional allowance is due. Provider is misrepresenting the items used and billed as implants and is misapplying the Texas Statute. As such, ForeSight contends the provider was adequately compensated for the implants up to a total allowance of $478.50."

Response submitted by: ForeSight

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 required elements for reimbursement of implants.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) 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.
- 10 – Upon review of submitted request for reconsideration. ForeSight has determined that no additional allowance will be made.
- 57 – Payment denied/reduce because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.

Issues

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

Findings

1. The requestor is seeking reimbursement of implants in the amount of $2,84.32 rendered as part of an outpatient hospital surgery on February 8, 2022. The codes in dispute were submitted on the medical bill as,
    - C1713 – Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
    - C1781 – Mesh Implantable

   The description on the itemized bill indicates,
    - C1713 – ABS Short Fixed-Device with a billed amount of $1011.65
    - C1713 Fasttouch suture Tacks with a billed amount of $465.00

- C1713 – Fasttouch ?Suture Fixatio with a billed amount of $963.00
- C1781 – Mesh Surg Onflex 5.6 x 3 with a billed amount of $582.90

Review of the submitted operative report found the description, "We then repaired the indirect hernia by ligating it and transfixing the vessels with 2-0 Vicryl suture. The floor was repaired with a medium OnFlex patch placed in the preperitoneal position. Straps were then placed around the spermatic cord. Onlay patch was placed in the pubic tubercle with a 2-0 Vicryl suture."

Review of the submitted implant log found the following,

- Modified ONFlex Mesh quantity one.
- Fas Touch Permanent Fixation System (not implanted).
- FTPC10 (not implanted).
- Covidien ABSTACK20S quantity one.

DWC finds the reimbursement of the implants cannot be determined as the requestor did not submit invoices to support the cost of the implants.

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

		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.