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

Respondent Name
Utica Mutual Insurance Co

MFDR Tracking Number
M4-24-0028-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
September 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 20, 2023	131-250	$321.11	$0.00
February 20, 2023	131-258	$13.27	$0.00
February 20, 2023	131-259	$46.77	$0.00
February 20, 2023	131-272	$1,170.38	$0.00
February 20, 2023	C1755	$158.00	$15.80
February 20, 2023	C1772	$11,760.00	$1,000.00
February 20, 2023	62362	$0	$0.00
February 20, 2023	X9907	$1,185.00	$0.00
	Total	$14,684.53	$1,015.80

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They submitted a document titled "Reconsideration" addressed to the Texas Department of Insurance (TDI). Requests for reconsideration must be sent to the correct workers' compensation carrier not TDI. This document states, "According to TX Workers Compensation guidelines the expected reimbursement for DOS 2/20/23 is $23,909.53. …Please note that implant invoices are enclosed for review, and should be reimbursed at manual cost plus 10% per TX Rule 134.402."

Supplemental response October 26, 2023. "Provider received payment in the amount of $11,918.00 and balance of $2,766.53 still owed. Please provide determination letter."

Supplemental response October 26, 2023. "EOB enclosed for review."

Amount in Dispute: $14,684.53

Respondent's Position

"I am writing in response to Baylor Surgical request for balance owed for 2/20/23 dos. Initially we issued payment of $9,255 on 4/5/23. Then after discussing this dos with the providers office we paid and confirmed receipt of, an additional $11,918 issued on 9/11/23 check# 2149872. This bill has been satisfied."

Response submitted by: Utica National Insurance Company

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 252 – An attachment /other documentation required to adjudicate this claim/service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Additional payment made on appeal/reconsideration.

Issues

1. What services are in dispute?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in February of 2023. The submitted DWC-60 indicates dispute amounts for the following.

   - 131 - 250 $321.11
   - 131 - 258 $13,27
   - 131 - 259 $46.77
   - 131 - 272 $1,170.38
   - C1755 - $158.00
   - C1772 - $11,760.00
   - X9907 - $1,185.00

   Review of the submitted DWC60 and medical bill found for type of bill 131 with revenue codes 250, 258, 259, 272 and x9907 are not separately payable per the applicable fee guideline shown below. Code 62362 is not in dispute leaving only Codes C1755 and C1772 (implants) to be considered in this review.

2. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC 134.403 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC 134.403 (g) 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.
   The itemized statement indicates the following items billed under revenue code 278.

   - "Kit Rev Sutrless Pump Con" as identified in the itemized statement and labeled on the invoice as "Rev Kit 8578 Sutrless Pump" with a cost per unit of $158.00;
   - "System Infusion 20cc Drug" as identified in the itemized statement and labeled on the invoice as "Pump 8637-20 SM II 20ml EMAN SYMBL" with a cost per unit of $11,760.00.

   The total net invoice amount (exclusive of rebates and discounts) is $11,918.00. 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 $1,015.80. The total recommended reimbursement amount for the implantable items is $12,933.80.

The total recommended reimbursement for the disputed services is $12,933.80. The insurance carrier paid $11,918.00. Additional payment of $1,015.80 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 Utica Mutual Insurance Co must remit to Baylor Surgical Hospital $1,015.80 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 2, 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.