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
New Hampshire Insurance Co

MFDR Tracking Number
M4-24-0211-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 28, 2023	C1713	$150.00	$0.00
February 28, 2023	C1781	$275.00	$144.59
February 28, 2023	23430	$8092.63	$0.00
February 28, 2023	29824	$0.00	0.00
February 28, 2023	29826	$0.00	0.00
February 28, 2023	29827	$0.00	0.00
	Total	$144.59 [sic]	$144.59

Requestor's Position

"This clean claim was billed requesting the surgical procedure be paid at 130% of CMS with separate reimbursement for our implants. According to Texas Workers Compensation Rule 134.402, "Implantable devices are reimbursed at the providers cost plus 10% up to $1,000.00 per item or $2,000.00 per case."

Amount in Dispute: $144.59

Respondent's Position

"This letter acknowledges receipt of your Liberty Health Care Network (HCN) complaint on

10/04/2023."

Response submitted by: Helmsman Management Services LLC.

Supplemental Response submitted October 17, 2023

The carrier agrees that it has paid provider $12,623.074. We are attaching a copy of the carrier's EOBs dated April 21, 2023, May 5, 2023 and June 16, 2023. The carrier's initial EOB recommended payment of $12,623.04. The reasoning is identified on the EOB. It remains the carrier's position that it has paid the provider all of the monies that the provider is entitled to. The provider is not entitled to any additional monies."

Response submitted by: Flahive, Ogden and Latson

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:

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 11 – Our recommended allowance for the supply was based on the attached invoice.
- 803 – Charge for this procedure exceeds the OPPS schedule allowance.
- 4097 – Paid per fee schedule; Charge adjusted because status dictates allowance is greater than provider's charge.

- X598 – Claim has been re-evaluated based on additional documentation submitted; No additional payment due.

Issues

1. Did the respondent support the claimant was in health care network?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of implants rendered at the time of an outpatient hospital surgery on February 28, 2023. Liberty Mutual responded on October 11, 2023 acknowledging the dispute stating claim was within the Liberty Health Care Network (HCN).

   Review of the submitted documentation found insufficient evidence to support the claimant is enrolled in the Liberty Mutual Health Care Network or that the provider (Baylor Orthopedic & Spine Hospital) is a network provider for Liberty Mutual Health Care Network.

   The supplement response received from the respondent on October 17, 2023 does not refer to a network claim nor does any of the submitted explanation of benefits.

   The Division finds there is insufficient evidence to support this is a network claim. The services in dispute will be reviewed per applicable fee guideline.

2. DWC Rule 28 TAC §134.403 (e)(2) states, "**Regardless of billed amount**, reimbursement shall be: if no contracted fee schedule exist that complies with Labor Code §413.011, 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 "Implantable, 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 of 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 items identified on the medical bill and itemized states under Revenue Code 278 are as follows:

   - "Staple Tendon Arthroscope" as identified in the itemized statement and labeled on the invoice as "Tendon Anchors" with a cost per unit of $650.00;
   - "Anchors Bone 3 w arthro" as identified in the itemized statement and labeled on the invoice as "Bone Anchors 3 w/ arthro del sys" with a cost per unit of $850.00;
   - "Implant Mesh" as identified in the itemized statement and labeled on the invoice as "Bioinductive Implant w/arth del lrg" with a cost per unit of $2,750.00.

   The total net invoice amount (exclusive of rebates and discounts) is $4,250.00. 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 $425.00. The total recommended reimbursement amount for the implantable items is $4,675.00.

The comprehensive surgical procedure fee is calculated as.

- Procedure code 23430 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is $6,397.05 multiplied by 60% for an unadjusted labor amount of $3,838.23, in turn multiplied by facility wage index 0.9562 for an adjusted labor amount of $3,670.12.

  The non-labor portion is 40% of the APC rate, or $2,558.82.

  The sum of the labor and non-labor portions is $6,228.94.

  The Medicare facility specific amount is $6,228.94 multiplied by 130% for a MAR of $8,097.62.

The total recommended reimbursement for the disputed date of service is $12,772.62. The insurance carrier paid $12,623.04. The requestor is seeking additional reimbursement of $144.59. 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 New Hampshire Insurance Co must remit to Baylor Orthopedic & Spine Hospital $144.59 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 25, 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.