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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-24-0217-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 12, 2023	C1713	$6,292.00	$0.00
	Total	$6,292.00	$0.00

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, "Please note that reimbursement was requested in Box 80 of UB-04 form for implants, and should be reimbursed at manual cost plus 10%".

Amount in Dispute: $6,292.00

Respondent's Position

"Our position is that no payment is due."

Response submitted by: Texas Mutual

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the billing and coding guidelines for durable medical equipment.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-18 – Exact duplicate claim/service.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.
- DC7 – Duplicate appeal. Network contract applied by Workwell, TX network.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 350 – In accordance with TDI-DWC Rule 134.480, this bill has been identified as a request for reconsideration or appeal.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 768 – Reimbursed per O/P FG at 130%. Separate reimbursement for implantables (including certification) was requested per Rule 134.403(G).

- 892 – Denied in accordance with DWC Rules and/or medical fee guidelines including current CPT Code descriptions/instructions.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of implants that were part of an outpatient hospital surgical procedure on January 12, 2023. The insurance carrier denied the claim line for the implants as claim lacking information.

   DWC Rule 28 TAC §134.403 (g) states in pertinent part, "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…"

   Review of the submitted documentation found only screen shots of "BOSHA MATERIALS STORAGE." These screen shots are not invoices. The insurance carrier's denial is supported.

   No payment 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	November 7, 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.