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
Liberty Mutual Insurance Corp

MFDR Tracking Number
M4-24-0220-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
September 18, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 8, 2022	C1713	$178.00	$0.00
December 8, 2022	C1781	$270.00	$57.50
	Total	$448.00	$57.50

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" addressed to Texas Department of Insurance. Requests for reconsideration must be submitted to the correct workers' compensation carrier not TDI. This document states, "The charges were not paid correctly per TX work comp fee schedule. According to TX workers compensation fee schedule the expected reimbursement for DOS 12/08/2022 is $13.020.63. …implants… should be reimbursed at manual cost plus 10%."

Amount in Dispute: $448.00

Respondent's Position

"LMI allowed payment at the line charge amount, this is the lesser of, invoice amount vs. net amount plus 10%. LMI paid the billed charge for C1713 of $1,780.00 and the billed charge of C1781 of $2,700.00. LMI cannot pay the provider higher than the line charge / invoice amount as

advised in the Texas Administrative Code."

Response submitted by: xxx

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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 4097 – Paid per fee schedule. Charge adjusted because statute dictates allowance is greater than provider's charge.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Is the respondent's position supported?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "LMI cannot pay the provider higher than the line charge / invoice amount as advised in the Texas Administrative Code." DWC Rule 134.403 (e) (2) states in pertinent part, **Regardless of billed amount**, reimbursement shall be when no contracted fee schedule exists… …the maximum allowable reimbursement (MAR)

amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables. The respondent's statement regarding cannot pay higher than the line charge is not supported. The services in dispute will be reviewed per applicable fee guideline,

2. The requestor is seeking additional payment of implants utilized in an outpatient hospital procedure rendered in December 2022.

   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 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 following items were submitted on the medical bill under Revenue Code 278 and detailed on the itemized invoice.

   - "Anchors Bond 3 w arthro" as identified in the itemized statement and labeled on the invoice as "Anchors Bone 3 w arthro del sys" with a cost per unit of $650.00;
   - "Staple Tendon Arthroscop" as identified in the itemized statement and labeled on the invoice as "Staple Tendon Arthroscopy" with a cost per unit of $350.00;
   - "Suture Anchor 4.75 x 14m" as identified in the itemized statement. No invoice was found to support the cost of this implant. No reimbursement is recommended.
   - "Suture Anchor Swivelock" as identified in the itemized statement and labeled on the invoice as "DBL Loaded 4.75 Swvlk" with a cost per unit of $425.00;
   - "Implant Mesh Bioinductive" as identified in the itemized statement and labeled on the invoice as "Implant Mesh Bioinductive" with a cost per unit of $2,700.00.

   The total net invoice amount (exclusive of rebates and discounts) is $4,125.00. 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 $412.50. The total recommended reimbursement amount for the implantable items is $4,537.50.

3. The total recommended reimbursement for the disputed services is $4537.50. The insurance carrier paid $4,480.00. The amount due is $57.50. 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 Liberty Insurance Corp must remit to Baylor Surgical Hospital $57.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 20, 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.