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
Memorial Hermann Surgical

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-24-0240-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
October 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 25, 2023	C1713	$550.00	$0.00
May 25, 2023	C1776	$9,350.00	$0.00
	Total	$9.900.00	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a document titled "Reconsideration" addressed to the Texas Department of Insurance. Requests for reconsideration must be sent to the correct workers' compensation carrier not TDI. This document states, "Per EOB received payment was disallowed for Rev code 278 due to missing implant invoices. Please note that implant invoices are enclosed along with cost certification letter, and implants should be reimbursed at manual cost plus 10%".

Amount in Dispute: $9,900.00

Respondent's Position

"The carrier finds no payment is due for explanted implant 71420574 (resurfacing patella), no payment for 74022116 as there was no invoice received. Texas Administrative Code Rule 134.403 advised that implant is an object or device that is surgically implanted, explanted item 71420574 is not due for payment. Continued in Texas administrative Code Rule 134.403 the provider is required to supply a manufacturer invoice for payment of implants, no payment is due for items without invoice. The provider is also requesting payment of implants higher than billed charge, C1713 line charge of $500.00 with the dispute amount of $550.00. Texas Administrative Code Rule 134.403 advises the provider shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount plus 10%."

Response submitted by: Liberty 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 outpatient hospital procedures.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) 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.
- 8 – The supply charge was disallowed as it was not adequately identified. Please resubmit with invoice.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 876 – Fee schedule amount is equal to the charge.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- B13 – Previously paid. Payment for this claim/service may have been provided in a

previous payment.

- 802 – Charge for this procedure exceeds the OPPS schedule allowance.

Issues

1. Did the requestor meet the requirements of applicable Division Rules?

Findings

1. The requestor is seeking reimbursement of implants rendered during an outpatient hospital surgical procedure in May of 2023.

   DWC Rule TAC §134.403 (g)(1) states, "A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive or rebates and discounts) for the implantable. The certification shall include the following sentence: "I herby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   Review of the submitted documentation found no billing certification that complies with the rule shown above.

   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

Signature	Medical Fee Dispute Resolution Officer	October 27, 2023 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.