TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Memorial Hospital

Respondent Name
East Texas Education Insurance Assoc

MFDR Tracking Number
M4-24-0505-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
October 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 23, 2022	250	$0.00	$0.00
November 23, 2022	C1762	$2,336.95	$0.00
November 23, 2022	80053	$0.00	$0.00
November 23, 2022	85027	$0.00	$0.00
November 23, 2022	71046	$0.00	$0.00
November 23, 2022	24358-RT	$0.00	$0.00
November 23, 2022	370	$0.00	$0.00
November 23, 2022	J0690	$0.00	$0.00
November 23, 2022	J1100	$0.00	$0.00
November 23, 2022	J1170	$0.00	$0.00
November 23, 2022	J2405	$0.00	$0.00
November 23, 2022	J2704	$0.00	$0.00
November 23, 2022	J3010	$0.00	$0.00
November 23, 2022	J7050	$0.00	$0.00
November 23, 2022	J7120	$0.00	$0.00
November 23, 2022	J8501	$0.00	$0.00
November 23, 2022	710	$0.00	$0.00
November 19, 2022	93005	$0.00	$0.00
	Total	$2,336.95	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR). The requestor did include a copy of their reconsideration that states, "Providence Memorial Hospital has identified an underpayment in the amount of $19,053.81. According to our participating provider contract with Claims Administrators, implants (CPT code C1762) should have a separate reimbursement of $4,250.40. The total expected reimbursement for the entire bill is $7,803.94. We have received a payment of $5,466.99, leaving an underpayment of $2,336.95."

Amount in Dispute: $2,336.95

Respondent's Position

"Attached are copies of the bills we received where the provider did not request separate implant reimbursement in box 80 of the UB04. It is our position that payment issued has been correct and no additional reimbursement is due."

Response submitted by: Claims Administrative Services, Inc.

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 services.

Denial Reasons

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

- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 616 – This code has a status Q APC indictor and is packaged into other APC codes that have been identified by CMS.

- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.

Issues

1. Is the respondent's position supported?

2. What rule is applicable to reimbursement?

Findings

1. The respondent states in their position statement, "Attached are copies of the bills we received where the provider did not request separate implant reimbursement in box 80 of the UB04." DWC Rule 28 TAC §134.403(g)(2) states in pertinent part, "A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B) of this title.

   The requestor is seeking reimbursement of Code C1762 – Connective tissue, human (includes fascia lata) or implant. The respondent's position is not supported.

2. DWC Rule 28 TAC §134.403(g)(1) 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.

   (1) 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 of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby 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 invoice to support the cost of the implanted item. Based on this review, the DWC finds the requirements of separate reimbursement for implants is not met. 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	November 30, 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.