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**
Arch Indemnity Insurance Co

**MFDR Tracking Number**
M4-24-0880-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
December 19, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| May 15, 2023 | C1713 | $4,688.97 | $0.00 |
| May 15, 2023 | C1781 | $2,750.00 | $0.00 |
| | **Total** | $7,439.97 | $0.00 |

## Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit document titled "Reconsideration" dated December 5, 2023 that states, "The charges were not paid correctly per TX workers compensation guidelines. According to TX workers compensation fee schedule the expected reimbursement for DOS 5/16/2023 is $15,812.01. Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

**Amount in Dispute:** $7,439.97

## Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

**Supplemental response submitted February 8, 2024**

Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question were escalated and a review completed. Our bill audit company has determined no further payment is due. Rationale: Our Fee schedule team has confirmed services reviewed appropriately at Medicare 200% with implants being denied for invoice."

**Response submitted by**: Gallagher Bassett

## 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 fee guidelines for outpatient hospital services.

Denial Reasons

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

- 5721 – To avoid duplicate bill denial for all reconsiderations adjustments/additional payment requests, submit a copy of this EOR or clear notation.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 16 – Claim/service lacks information or has submission/billing error(s) which is need for adjudication.
- 5283 – Additional allowance is not recommended as the bill was reviewed in accordance with state guidelines, usual and customary policies, providers contract or (illegible).
- 5998 – ESS Recon logic.
- 90563 – Original payment decision is being maintained upon review it was determined that this claim was processed properly.
- 90950 – This bill is a reconsideration of a previously reviewed bill allowance amounts reflect any changes to the previous payment.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of implants rendered as part of outpatient surgical procedure in May of 2023. The insurance carrier denied the disputed service based on missing information/incomplete claim.

   DWC Rule 28 TAC §134.403 (g) 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 the required certification of cost.

   Review of the itemized statement found the following items were billed under Revenue Code 278.

   - "Staple Tendon Arthroscope" as identified in the itemized statement. No invoice to support the cost of the implant was included in the documentation.
   - "Anchors Bone 2 W Arthro" as identified in the itemized statement. No invoice to support the cost of the implant was included in the documentation.
   - "Anchor Sut 4.75MM x 19.1" as identified in the itemized statement. No invoice to support the cost of the implant was included in the documentation
   - "LNT Implant System 4.75" as identified in the itemized statement. No invoice to support the cost of the implant was included in the documentation.
   - "Implant Mesh Bioinductive" as identified in the itemized statement. No invoice to support the cost of the implant was included in the documentation.

   The DWC finds the request for implant reimbursement cannot be made as insufficient information was found to support the cost of each item submitted under Revenue Code 278.

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**

| | | |
|---|---|---|
| | Peggy Miller | February 15, 2024 |
| 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.