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
TOPS Surgical Specialty Hospital

Respondent Name
Texas Municipal League Intergovernmental

MFDR Tracking Number
M4-24-0901-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 17, 2023	C1713	$5,880.57	$0.00
	Total	$5,880.57	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled; "Reconsideration" dated December 27, 2023 that states. "According to TX Workers Compensation fee schedule the expected reimbursement for DOS 4/17/2023 is $18,966.32. Please note that additional implant invoices are enclosed for review, and should be reimbursed at manual cost plus 10%."

Amount in Dispute: $5,880.57

Respondent's Position

The carrier believes that it has overpaid the provider. The total amount paid by the carrier for implants was $4,525.43 but they should have been allowed at $1,4502 [sic] plus $479.93 equals $1,928.93. Thus, the provider was overpaid by $2,596.60. The total amount paid was $13,185.85. This was based upon payments of $8,560.32 plus $4525.53. However, the carrier's calculations are that payment should've been made of $8,560.32 plus $1,928.93 for a total of $10,489.25… Accordingly, the provider is not entitled to any additional payment…"

Response submitted by: Flahive, Ogden and Latson

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.

- 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.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 618 – The value of this procedure is packaged into the payment of other service performed on the same date of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- U03 – The billed service was reviewed by UR and authorized.
- 18 – Exact duplicate claim/service.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- 426 – Reimbursed to fair and reasonable.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.

Issues

1. What rule is applicable to reimbursement?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for implants rendered as part of an outpatient hospital surgery in April 2023. The insurance carrier provided evidence of three payments made after reconsideration for Code C1713.

    - June 5, 2023 - $2,420.00
    - June 9, 2023 - $1,452.00
    - September 27, 2023 - $653.43
    - Total - $4,525.43

    The requestor is seeking an additional payment of $5,880.57. The applicable DWC fee guideline calculation is shown below.

2. 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."

    Review of the submitted medical bill and itemized statement found the following items billed under Revenue Code 278 and Code C1713.

    - "Anchor Sut 2.9mm x 12.5m" as identified in the itemized statement and labeled on the invoice as "Anchor Sut 2.9mm x 12.5mm shoulder" with a cost per unit of $433.60;

    - "Anchor Bone Self Bunching" as identified in the itemized statement and labeled on the invoice as "Self Bunching KL 1.8 Fibertak , shoulder" with a cost per unit of $440.00 at 3 units, for a total cost of $1,320.00.

The total net invoice amount (exclusive of rebates and discounts) is $1,753.60. 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 $175.36.

The total recommended reimbursement amount for the implantable items is $1,928.96.

The insurance carrier paid $4,525.43. Additional payment is not 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	January 24, 2024 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 DWC's webpage; DWC045 form. 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.