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 Orthopedic & Spine Hospital

Respondent Name
Arch Indemnity Insurance Co

MFDR Tracking Number
M4-23-2652-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 16, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 13, 2023	C1713	$39.80	$39.80
January 13, 2023	C1781	$275.00	$275.00
January 13, 2023	C9399	$150.00	$150.00
	Total	$464.80	$464.80

Requestor's Position

"Please note that implants were not paid correctly per TX Rule 134.402, which implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $13,021.04 leaving a balance of $464.80."

Amount in Dispute: $464.80

Respondent's Position

"This letter acknowledges receipt of your Network (HCN) complaint of June 27, 2023. Complaints must be made no later than 90 days after the date of the issue arises that is the basis of the complaint.

Response submitted by: Gallagher Bassett

Supplemental response submitted by Flahive, Ogden & Latson July 11, 2023

"The provider is not entitled to any additional payment. The carrier has paid the provider all of the monies that it is entitled to… The carrier is not direct in Texas Administrative Code Rule 134.403 to apply 10% increase to the provider's billed charge. The provider billed less than Texas Administrative Code Rule 134.403 allowance for implant reimbursement with the calculation of additional 10 percent markup. The carrier is not required to increase the implant line charge to allows the 10 percentage markup when lesser of language is allowed for implants."

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 reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 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 package or excluded from payment.
- 11 – The recommended allowance for the supply was based on the attached invoice.
- 875 – Fee schedule amount is equal to the charge.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B13 – Previously paid. Payment for this claim/service may have been provided in previous payment.
- X598 – Claim has been re-evaluated based on additional documentation submitted; No additional payment due.

Issues

1. Did the respondent support this is a network claim?

2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in pertinent part, "The provider is not entitled to Medical Fee Dispute Resolution at the Medical Review Division level. In fact, since the claimant is in a certified health care network, the only medical fee venue appropriate would be through the network itself. The claimant is in the Coventry Health Care Network." Review of the submitted documentation and information known to the Division found insufficient evidence to support the injured worker is within a certified health network. These statements will not be considered in this review.
2. The requestor is seeking additional reimbursement of the implants rendered as part of an outpatient procedure in January 2023. The insurance carrier reduced the payment based on the submitted invoice and submitted invoices.

   DWC Rule 28 TAC §134.403 (e) (2) and (g) states, " **Regardless of billed amount**, reimbursement shall be:

   > (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

   (g) 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.

   The insurance carrier's reduction is not supported. The reimbursement of the implants will be reviewed per applicable fee guideline.

   The following items were billed under Revenue Code 278.

   - C1713 - Anchor 3.5mm Miti Suture (2) units with a billed amount of $398.00. Submitted invoice indicates Anchor 3.5mm miti suture with a cost of $199.00 each.
   - C1781 - Implant Mesh Bioi9nducitiv (1) unit with a billed amount of $2750.00. Submitted invoice indicates Implant Mesh Bioinductive with arthroscopic delivery system a cost of $2750.00
   - C9399 - Versawrap Tendon Protect (1) unit with a billed amount of $1500.00. Submitted invoice indicates Versawrap Tendon Protector with a cost of $1500.00.
3. The total recommended reimbursement for the disputed services is $4,648 x 10% per Rule 134.403 (g) = $464.80 for a total allowed amount of $5112.80. The insurance carrier paid $4,648.00. An additional payment of $464.80 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 Arch Indemnity Insurance Co must remit to Baylor Orthopedic & Spine Hospital $464.80 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 24, 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.