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
Old Republic Insurance Co

MFDR Tracking Number
M4-24-1682-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
April 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 6, 2023	C1713	$8,580.00	$2,722.50
	Total	$8,580.00	$2,722.50

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dated March 18, 2024 that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 9/6/2023 is $16,953.04. Please note that separate reimbursement was requested in Box 80 of UB-04 for implants, and implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: $8,580.00

Respondent's Position

"The Provider contends they are entitled to separate reimbursement for the implantables. In reviewing the documentation, however, the Provider did not indicate on the submitted billing that separate reimbursement for the implantables was being sought in accordance with Rule 134.403(f)(1)(B) and 134.403(g). Without requesting separate reimbursement of the implantables, the Provider is not entitled to separate reimbursement."

Response submitted by: Travelers

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.
3. 28 TAC §133.10 details the billing requirements when requesting implant reimbursement.

Denial Reasons

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

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

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

Findings

1. The requestor is seeking payment of implantables rendered during an outpatient procedure on September 6, 2023. The insurance carrier denied the implants as being packaged.

   DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits 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.

DWC Rule 28 TAC §134.403(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.

DWC Rule 28 TAC §134.403(g)(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."

DWC Rule 28 TAC §133.10(2)(QQ) states in pertinent parts, "The following data content or data elements are required for a complete institutional medical bill related to workers' compensation health care, (QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."

Review of the submitted medical bill found a request for implants was made in box 80 as required by applicable billing instruction. The submitted documentation included the required billing certification and invoices to support the cost. The calculation of the reimbursement is as follows.

- "Fibertak AR-3638" as identified in the itemized statement and labeled on the invoice as "Kit Disposable Curved Fibertak" with a cost per unit of $325.00 at 3 units, for a total cost of $975.00;

- "Anchor SP 2.6 MM Knotless" as identified in the itemized statement and labeled on the invoice as "Anchor SP 2.6 MM Knotless Fibertak" with a cost per unit of $750.00 at 2 units, for a total cost of $1,500.00.

2. The total net invoice amount (exclusive of rebates and discounts) is $2,475.00. 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 $247.50. The total recommended reimbursement amount for the implantable items is $2,722.50.

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 Old Republic Insurance Co must remit to Baylor Surgical Hospital $2,722.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 2, 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 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, 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.