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
Texas Association of Counties

MFDR Tracking Number
M4-24-1799-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
April 15, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 30, 2023	C1713	$888.69	$0.00
	Total	$888.69	$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 April 8, 2024 that states, "Per TX Rule 134.402, Implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $17,260.04."

Amount in Dispute: $888.69

Respondent's Position

"Provider correctly states that they are entitled to "the provider's cost + 10%" but erroneously misinterprets the status and is claiming the amount due is actually the charges of $8,887.00 + 10%, not the **cost** + 10%. Provider is asserting a balance due of more than what was charged."

Response submitted by: ForeSight

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.

- 10 – Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- 1014 – The attached (illegible) has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.
- 97 – 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.
- 6931 – Charges for surgical implants are reviewed separately by ForeSight Medical. Please expect a (illegible) explanation of review for surgical implant charges directly from ForeSight Medical and direct all surgical implant inquiries to ForeSight Medical.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of implants rendered during and outpatient hospital surgery on November 30, 2023. The insurance carrier reduced the disputed charges based on workers' compensation jurisdictional fee schedule. The implant reimbursement guidelines are as follows.

DWC Rule 28 TAC §134.403 (g)(1)(2) 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." The items billed under Revenue Code 278 and HCPCS Code C1713 are listed on the itemized statement as follows.

- Inspace US large 132. The submitted documentation includes a BaylorScott&White BOSHA Material Storage screen shot that detailed a cost of this item. This documentation is not a manufacturers invoice and does not support the cost of the implant. No reimbursement is recommended.

- Anchor Omega 6.5mm Peek. The submitted documentation includes a Stryker Invoice dated November 30, 2023 that indicates the cost of the implant is $198.00.

- Anchor Stryker Iconix. The submitted Stryker Invoice indicates a cost of $482.50.

- Anchor Omega 4.75mm Peek (2) units. The submitted Stryker invoice indications a cost of $420.75 each for a total cost of $841.50.

- Iconix speed Achoor [sic] W/2 (2) units. The submitted Stryker invoice indicates a cost of $482.50 for a total cost of $965.00.

The total supported cost of the implants is $2,487.00. This amount multiplied by 10% equals $248.70. $2,487.00 + $248.70 = $2,735.70.

The total recommended reimbursement of the implants is $2,735.70. The insurance carrier paid $8,887.00. No additional 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	May 16, 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, 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.