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
Crescent Medical Center

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-24-1887-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
April 25, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 28, 2023	29888 REV 360	-2.68	0.00
April 28, 2023	IMPLANTS REV 0278	9117.20	0.00
April 28, 2023	ALL OTHER	0.00	0.00
	Total	$9,114.52	$0.00

Requestor's Position

"We are requesting the MAR value of $22,600.20. Gallagher only allowed $13,485.68. Please pay the additional $9,114.52.

Amount in Dispute: $9114.52

Respondent's Position

"...ForeSight is disagreeing with the provider that an additional allowance is due for the implants. Provider has been paid in accordance with the Texas Statue for the implants. As such, ForeSight contends the provider has been adequately compensated for the implants with a total allowance of $8,291.80."

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 billing procedures for outpatient hospital medical bills.

Denial Reasons

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

ForeSight

- 1 – Reimbursement is based on the manufacturer's geo-specific true invoice cost for the conduct construct.
- 10 Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.

Gallagher Bassett

- 16 – Claim/service lacks information or has submission/billing effort(s) which is needed for adjudication.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 97-1 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 -2 – Workers' compensation jurisdictional fee schedule adjustment.
- 00100 – Any network reduction is in accordance with the Network referenced above.
- 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
- 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 packaged or excluded from payment.
- 5682 – Payment for this charge is not recommended without documentation of cost.

- 801 – Outlier payment has been proportional distributed to all covered OPPS services.
- 802-1 Charge for this procedure exceeds the OPPS schedule allowance.
- 877 -1 – Reimbursement is based on the contracted amount.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the respondent support contract reduction?
2. What rule is applicable to reimbursement?

Findings

1. The submitted explanation of benefits indicates a contract. Reference is made to Aetna Contract assigned to Coventry. Review of the submitted documentation does not support the injured employee is enrolled in a certified network or that a contract exists between the parties. Any contract reductions are not supported and will not be considered in this review.
2. The requestor seeks additional reimbursement of implantables rendered during outpatient surgical procedure in April 2023. The insurance carrier recommended payment based on the submitted invoices.

DWC Rule 134.403 (g)(1) 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 billing certification and manufacturer's invoices. The implants are reviewed as indicated below.

- C1713 - $5360.00 – Anchor 10x25mm femoral submitted on itemized statement. Submitted invoice indicates cost of $1072.00
- C1762 - $16755.00 – Tendon Anterior Tibialis submitted on itemized statement. Submitted invoice indicates cost of $3,351.00
- C1763 – 12875.00 – Implant 5x250mm Biobrace submitted on itemized statement.

Submitted invoice indicates cost of $2,575.00

- C1776 – 2700.00 – Tibial 11x30mm implant canulated submitted on itemized statement. Submitted invoice indicates cost of $540.00

The total net invoice amount (exclusive of rebates and discounts) is $7,538.00. 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 $753.80.

The total recommended reimbursement amount for the implantable items is $8,291.80. The insurance carrier paid $8,291.80. 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	June 20, 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.