



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-24-1962-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 8, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 5, 2023	C1713	\$5,213.98	\$0.00
Total		\$5,213.98	\$0.00

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 19, 2024 that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 9/05/2023 is \$13,587.02. Please note that separate reimbursement was requested in Box 80 of UB-04 form for implants, and implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: \$5,213.98

Respondent's Position

The Austin carrier representative for AIU Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 14, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available

Response submitted by: N/A

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 requirements of reimbursement of implants.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustment/additional payment request, submit a copy of this EOR or clear notat(illegible)
- 90223 – Workers' compensation jurisdictional fee schedule adjustment.
- 6183 - The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment...

Issues

1. Did the requestor adequately document the cost of the implantables?

Findings

1. The requestor is seeking additional reimbursement for implants rendered as part of an outpatient hospital surgery in September of 2023. The insurance carrier denied the charges as being bundled/packaged.

DWC Rule 28 TAC §134.403(g) states in pertinent part, "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,

which is less, but not to exceed \$2,000 in add-on's per admission."

Review of the submitted itemized statement and medical bill found the following items submitted under implantable revenue code 278 and code C1713.

- Knotless Tensiontight BU
- Anchor Sut 3mm x 12.7mm x 5
- System Implant Rotator

Review of the submitted documentation found no manufacturer's invoices or any other documentation to substantiate the cost of the implantables.

Based on the lack of required manufacturer's invoices, the cost of the implants cannot be certified nor can fee calculation be done. No separate reimbursement is recommended.

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

July 10, 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 electrónico CompConnection@tdi.texas.gov.