



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

General Motors LLC

MFDR Tracking Number

M4-24-1965-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

May 7, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 14, 2023	C1713	\$811.80	\$0.00
November 14, 2023	C1781	\$1,045.00	\$0.00
Total		\$1,856.80	\$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" that states, "Please note 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: \$1,856.80

Respondent's Position

"...Therefore, in conclusion, ForeSight is disagreeing with the provider that an additional allowance is due for the implants. Provider has been paid in accordance with the Texas Statute for the implants. As such, ForeSight contends the provider has been adequately compensated for the implants with a total allowance of \$4,567.20."

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.

- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 602 – Charge for this procedure exceeds the OPPS schedule allowance.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 1014 – The attached billing 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.
- 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical. Please expect a detailed explanation of review for surgical implant charges directly from ForeSight Medical and direct all surgical implant inquires to ForeSight Medical.
- 2 – Device payment was based on documentation provided by your facility.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of implants utilized in an outpatient hospital surgery rendered in November of 2023. The insurance carrier reduced the disputed services based on documentation provided by the facility.

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

Review of the documents included with this request for MFDR did not find manufacturers invoices to support the cost of items billed under Revenue Code 278 / Codes C1713 – Anchor Screw and C1781 – Mesh (Implantable).

No reimbursement 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 requestor 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 30, 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.