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 Mutual Insurance Co

MFDR Tracking Number
M4-24-2518-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
July 15, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 1, 2023	C1762	$11,225.50	$0.00
	Total	$11,225.50	$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 July 1, 2024 that states, "...Implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: $11,225.50

Respondent's Position

"The itemized statement shows revenue code 278 billed at $12,820.00 for 1 Avance allograft nerve. The invoice submitted shows the cost as $2,615.00 + 10% ($261.50) for an implant reimbursement of $2,875.50. The attached EOB shows Texas Mutual reimbursed $2,876.50 for revenue code 278. Our position is that no payment is due."

Response submitted by: Texas Mutual

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 reimbursement guidelines for implants rendered during outpatient surgery.

Denial Reasons

- 45 – Charge exceeds schedule/maximum allowable or contracted/designated fee arrangement.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- D25 – Approved non network provider for Workwell. TX Network claimant per Rule 1305.153 (C).
- 370 – The hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 768 – Reimbursed per O/P FG at 130% separate reimbursement for implantables (including certification) was requested per Rule 134.403(G).
- 897 – Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134: Subchapter (E) health facility fees.
- CAC - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC – 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the rule applicable to reimbursement?

Findings

1. The requestor is seeking additional reimbursement of an implant rendered during an outpatient hospital surgery on August 1, 2023. The insurance company reduced the approved amount based on DWC Rules and fee guidelines.

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

   Review of the submitted itemized statement showed under Revenue Code 278/HCPCS code C1762 a billed amount of $2,615.00. The submitted manufacturer's invoice shows a cost of $2,615.00. This amount multiplied by 10% equals ($261.50) by adding these two amounts together the maximum allowable amount (MAR) is $2,876.50.

   Review of the submitted explanation of benefits dated September 29, 2023 indicates a payment of $2,876.50. 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 additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 12, 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.