



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-24-2560-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

July 22, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 23, 2024	C1713	\$14,719.09	\$0.00
Total		\$14,719.09	\$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 8, 2024 that states, "Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: \$14,719.09

Respondent's Position

Per TAC rules 134.403(f)(1)(B) and 134.403(g), reimbursement for the implants on this medical bill was made as follows at invoice cost + 10%. Total implant reimbursement = \$2,475. Our position is that not additional 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 outpatient hospital services.

Denial Reasons

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3/350 – In accordance with TDI-DWC Rule 134,804, this bill has been identified as a request for reconsideration.
- CAC-18/224 – Exact duplicate claim/service.
- CAC -193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
- CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- DC3 – Additional reimbursement allowed after reconsideration.
- DC4 – No additional reimbursement allowed after reconsideration.
- D25 – Approved non network provider for Workwell, TX network claimant per Rule 1305.153(C).
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 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.

Issues

1. What is the rule applicable to reimbursement?

Findings

1. The requestor is seeking payment of implants rendered as part of an outpatient hospital surgical procedure. The insurance carrier reduced the payment based on workers compensation fee guidelines.

DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

DWC Rule 28 TAC §134.403 (g) 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 medical bill found the following items submitted under Revenue Code 278 and HCPCS Code C1713.

- "Screw Monoax locking 3.5" as identified in the itemized statement and labeled on the invoice as "Plate anthem" with a cost per unit of \$250.00;
- "Screw Monoax locking 3.5" as identified in the itemized statement and labeled on the invoice as "Non-locking screw" with a cost per unit of \$75.00 at 2 units, for a total cost of \$150.00;
- "Plate anthem one third" as identified in the itemized statement and labeled on the invoice as "Non-locking screw" with a cost per unit of \$75.00;
- "Screw non-locking 2.5x1" as identified in the itemized statement and labeled on the invoice as "MonoAx Locking screw" with a cost per unit of \$150.00;
- "Screw non-locking 3.5x1" as identified in the itemized statement and labeled on the invoice as "MonoAx Locking screw" with a cost per unit of \$150.00;
- "Screw Monoax locking 3." as identified in the itemized statement and labeled on the invoice as "Captivate 4.0x44mm cannulated screw" with a cost per unit of \$250.00 at 2 units, for a total cost of \$500.00;
- "Screw Monoax locking 3." as identified in the itemized statement as Mono Ax locking screw with a cost per unit of \$150.00;
- "Screw Captivate 4.0x44mm" as identified in the itemized statement as Captivate 4.0x44mm cannulated screw with a cost per unit of \$250.00 at 2 units, for a total cost of \$500.00.

The total net invoice amount (exclusive of rebates and discounts) is \$2,250.00. 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 \$225.00. The total recommended reimbursement amount for the implantable items is \$2,475.00.

The total recommended reimbursement for the disputed services is \$2,475.00. The insurance carrier paid \$2,475.00. 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 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

		August 29, 2024
Signature	Medical Fee Dispute Resolution Officer	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.