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
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-24-2599-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
July 26, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 10, 2023	111-278	$3,992.49	$0.00
	Total	$3,992.49	$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 July 16, 2024, that states, "According to EOB receive Rev code 278 was not paid correctly per TX work comp guidelines. According to TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: $3,992.49

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett

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.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5407 – CV: Reconsideration, no additional allowance recommended. This bill and submitted documentation have been re-evaluated by Clinical Validation.

Issues

1. Did the requestor support the cost of the implants?

Findings

1. Baylor Orthopedic & Spine Hospital is seeking additional reimbursement for implants rendered during outpatient surgery rendered on October 10, 2023. The insurance carrier denied the disputed services due to lack of information and/or billing errors.

   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 documentation found insufficient evidence to support the cost of the disputed services billed under Revenue Code 278 in the amount of $9,150.00. No reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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	September 13, 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.