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 Surgical Hospital

Respondent Name
National Surety Corp

MFDR Tracking Number
M4-24-2936-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 26, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 3, 2024	C1781	$2,860.00	$0.00
January 3, 2024	C1713	$809.80	$0.00
January 3, 2024	29827	$95.71	$0.00
	Total	$3,765.51	$0.00

Requestor's Position

The requestor did not submit a position statement but rather a document titled "Reconsideration" dated August 15, 2024 that states "According to TX Workers Compensation Rule 134.402, "Implantable devices are reimbursed at the providers cost plus 10% up to $1,000 per item or $2,000 per case. "Please note that implant invoices are enclosed for review."

Amount in Dispute: $3,765.51

Respondent's Position

"EOR ALTX 1673 – **Paid $14,220.15** provider been overpaid. Provider is seeking separate implant payment for a total of $15,385.66, Provider only documented $2001.00 in implant invoices for a total allowable of $2201.10…".

Response submitted by: enlyte

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 documentation requirements when implant reimbursement is requested.

Denial Reasons

- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 197 - Precertification/authorization/notification/pre-treatment absent.
- 95 – Plan procedures not followed.
- U00 – There was no UR procedure/treatment request received.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- M127 - Missing patient medical record for this invoice.
- MA27 – Missing/incomplete/invalid entitlement number or name shown on the claim.
- MA30 – Missing/incomplete/invalid type of bill.
- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking payment of implants rendered as part of outpatient surgical procedure on January 3, 2024.

   DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits 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) states, "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."

   The documentation included with this request for MFDR included an invoice from Arthrex. This invoice indicates a shipped date of January 4, 2024. This date is after the date of the surgery, January 3, 2024.

   As the cost of the implants is not supported by the information available at the time of review, the Division finds no 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	January 3, 2025 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.