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
American Zurich Insurance Co.

MFDR Tracking Number
M4-25-0133-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 16, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 2, 2024	C1713	$713.83	$0.00
May 2, 2024	C1781	$4,235.00	$0.00
	Total	$4,948.83	$0.00

Requestor's Position

"Per EOB received CPT codes C1713 and C1781 disallowed payment for being inclusive. Please note that separate reimbursement was requested in Box 80 of UB-04 form for implants, and per TX Rule 134.402 implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $13,127.16. Please reprocess and remit payment for remaining balance due."

Amount in Dispute: $4,948.83

Respondent's Position

"Prior to the carrier's EOB dated October 3, 2024, the carrier had already paid the provider the amount of $13,127.16. The carrier's EOB dated October 3, 2024, recommended an additional payment of $354.52. The carrier is paying that amount. It is the carrier's position that no monies are owed beyond the $354.52."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031and 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.

Adjustment Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- P13 - PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES, USE ONLY IF NO OTHER CODE IS APPLICABLE.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- Comment from EOB posted October 3, 2024 – ALLOWANCE CHANGE

Issues

1. Has the insurance carrier allowed additional reimbursement for the disputed services after the request for medical fee dispute resolution (MFDR) was received by DWC?
2. What rules apply to the reimbursement of the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. A review of the DWC060 Medical Fee Dispute Resolution (MFDR) Request form finds that this request for MFDR was received by DWC on September 16, 2024. The services and amounts in dispute per the DWC060 request form are shown in the "Summary of Findings" table above.

   A review of the documentation submitted finds that per an explanation of benefits (EOB) dated October 3, 2024, the insurance carrier allowed reimbursement for the services in dispute in the following amounts:

   - For CPT code C1713 the insurance carrier allowed reimbursement in the amount of $713.93.

- For CPT code C1781 the insurance carrier allowed reimbursement in the amount of $4,235.10.

DWC finds that the services in dispute were allowed reimbursement in the disputed amounts after the request for MFDR was received by DWC.

2. This dispute involves outpatient hospital facility services in which separate reimbursement for implantable items was requested on the medical bill.

   DWC finds that 28 TAC §134.403 applies to the reimbursement of the services in dispute.

   28 TAC §134.403 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract exists, reimbursement shall be 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 (f) states in pertinent part "the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 200 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent…
   (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."

3. The requestor is seeking additional reimbursement in the amount of $713.83 for surgical implantable items billed under disputed CPT code C1713 and in the amount of $4,235.10 for implantable items billed under CPT code C1781.

   As established in finding number one above, per the EOB dated October 3, 2024, DWC finds that the insurance carrier has allowed reimbursement for the implants at cost plus 10 percent, the amounts that the requester is seeking in this MFDR request. Therefore, DWC finds that no additional reimbursement is due.

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 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	November 5, 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.