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
North Central Surgical Hospital

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-25-0573-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
November 6, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 1, 2024	C1713	$5,311.33	$0.00
May 1, 2024	27814	-$4,579.90	$0.00
	Total	$731.43	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated October 24, 2024 that states, "Per EOB received CPT code C1713 was disallowed payment. Please note that separate reimbursement was requested in Box 80 of UB-04 form."

Amount in Dispute: $731.43

Respondent's Position

"After review of the documents provided, we are upholding our prior recommended allowance for the implants (2,864.35.00) as provider has not supplied manufacturer invoice(s). ForeSight's review was in accordance with the Texas Statutes, the Operative Report and Implant Log provided. Therefore, in conclusion, ForeSight is disagreeing with the provider that an additional

allowance is due for the implants without appropriate submission of manufacturer invoice(s). Provider has been paid in accordance with the Texas Statute for the implants."

Response submitted by: ForeSight

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

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- (illegible) – Charge for this procedure exceeds the OPPS schedule allowance.

Foresight reduction codes

- 14 – This item was determined to not have been permanently implanted during the procedure.
- 2 – Device payment was based on documentation provided by your facility.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment implants rendered during an outpatient hospital procedure rendered on May 1, 2024. The insurance carrier made reductions based on documentation and workers' compensation fee schedule.

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 submitted documentation did not include the manufacturer's invoice to support the cost of the implant charges. 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

		January 16, 2025
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 electronico CompConnection@tdi.texas.gov.