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
AIU Insurance Co

MFDR Tracking Number
M4-25-1812-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 30, 2024	C1713	$5,766.26	$0.00
July 30, 2024	L8699	$1,382.70	$0.00
	Total	$7,148.98	$0.00

Requestor's Position

The requestor submitted a document titled "Reconsideration" dated January 7, 2025 that states, "Per EOB received CPT code 27535 was denied payment due to treatment was deemed by the payer to have been rendered in an inappropriate, or invalid place of service. Please note that authorization was obtained for treatment for outpatient services, and proof of authorization enclosed for review."

Amount in Dispute: $7,148.98

Respondent's Position

"Our bill audit company has determined that no further payment is due. …The bill was denied by Clinical Validation for "We are unable to complete review of implant charges without documentation of cost or invoices for each implanted item billed." Purchase order was submitted, not manufacture's invoice. To date, including the sate dispute, the provider still has

not submitted the manufacture's invoices, which are required per state guidelines."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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 billing fee guidelines for services rendered at outpatient hospital.

Denial Reasons

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

- 00663 – Reimbursement has been calculated based on the state guidelines.
- 16/9084 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 5243 – CV: We are unable to complete review of implant charges without documentation of cost or invoices for each implanted item billed.
- 58/90120 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
- 5920 – Fee Schedule manually priced at billed charge.
- 6183 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 798 – Service is only reimbursed on an inpatient basis.
- P12/90223 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What rule is applicable to outpatient hospital services?

Findings

1. The requestor is seeking reimbursement of implants that were rendered during an outpatient hospital service on July 30, 2024.

The requestor only lists code C1713 – Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable) and L8699 – Prosthetic implant not otherwise specified on the DWC060. Review of the submitted medical bill found these implants were rendered as part of surgery billed under code 27535 – open reductio and internal fixation of unicondylar proximal tibial plateau fracture.

DWC Rule §134.403 (d) states, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…"

The Medicare payment policy specific to outpatient procedures is found at, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf states in pertinent part, "*10.1.1 - Payment Status Indicators (Rev. 1445; Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08) An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule*."

Review of the status indicator of code 27535 indicates, "C" Inpatient procedures not paid under OPPS. Admit patient. Bill as inpatient.

DWC Rule 134.403 (h)(i)(j) states,

For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

> (1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:
>
> (A) the reimbursement amount;
>
> (B) a description of the services to be performed under the agreement;

(C) any other provisions of the agreement; and

(D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

The information submitted with the request for MFDR contained a utilization review conducted on July 22, 2024 to determine the medical necessity of the proposed services. This document does not meet the requirements of the rules pertaining to "alternative site authorization" shown above.

The requestor's request for the implants cannot be considered for reimbursement as the surgical procedure is not covered and the documentation presented relating to the implant cost was a sales order and purchase order not manufacturer's invoices.

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 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 reimbursement for the disputed services

Authorized Signature

	Medical Fee Dispute Resolution Officer	May 9, 2025
Signature		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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.