TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
St Lukes the Woodlands

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-4130-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We did not request separate reimbursement for the implant charges on our original submission. When the carrier processed the bill and paid accordingly, we then submitted the appeal with the certified invoices. Per TDI rule 134.403. Our implant cost is $3600.00 x 10% = $3960.00. This is the amount we seek for Medical dispute."

Amount in Dispute: $3,960.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor did not request separate reimbursement of implantables. As such, the insurance carrier paid the bill at the 200% all-inclusive rate-without separate reimbursement of implants."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2018 - September 7, 2018	Outpatient Hospital Services	$3,960.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 234 – This procedure is not paid separately
   - RN – Not paid under OPPS: services included in APC rate

- P14 – Payment is included in another svc/procdre occurring on same day
- 18 – Duplicate Claim/Service

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement in the amount of $3,960.00 for outpatient hospital services rendered on September 4, 2018. The insurance carrier reduced disputed services as not separately payable.

   The requestor states, "…we then submitted the appeal with the certified invoices." Review of the information available to the Division found insufficient evidence to support the assertion made by the requestor.

   28 TAC §134.403, (g) (1) and (2) states,

   > (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."
   >
   > (2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B) of this title.

   DWC has reviewed the available information and found insufficient evidence of the certification of implants. The carrier's request for separate reimbursement of the implants is not supported. No additional payment is recommended.

Conclusion

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

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 13, 2019
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.