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
Heritage Park Surgical Hospital

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-21-0687-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 18, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB, carrier did not pay correctly according to TX Fee Schedule, Rev 278 is paid at cost + 10%. Carrier capped the payment for this line item at Billed Charges."

Amount in Dispute: $851.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The previous review is being maintained (Payment of $18,186.71) and no additional allowance is recommended as the Payment Adjustor Factor was applied in accordance with the DWC guidelines."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 8-9, 2020	Outpatient Hospital Services	$851.14	$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 or denied the payment for the disputed services with the following claim adjustment codes:
    - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
    - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
    - 95 – Plan procedures not followed

- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

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

Findings

The requestor is seeking additional reimbursement in the amount $851.14 for implants rendered during an outpatient surgical procedure in January 2020. The insurance carrier's payment was based on APC rate and workers' compensation fee schedule

28 TAC §134.403 is the rule applicable to outpatient hospital services and section (g) (1) states, 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."

Review of the submitted documentation found no documents to support the amount billed represents the actual cost or the specific language required by rule.

No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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

Signature	Medical Fee Dispute Resolution Officer	January 7, 2021 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

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