



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

Great American Alliance Insurance Co

MFDR Tracking Number

M4-21-1255-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 22, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB expected reimbursement for implants was partially paid. In accordance with the TX WC guidelines, when separate reimbursement is requested in box 80 of UB04 implants should be paid at manual cost + 10%."

Amount in Dispute: \$5,610.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Great American Alliance Insurance Co is Flahive Ogden & Latson who was notified of this medical fee dispute on March 30, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 19, 2019	Implants	\$5,610.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced or denied the payment for the disputed services with the following claim

adjustment codes:

- 16 – Claim/service lacks information or has submission/billing error(s)
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- P12 – Workers’ compensation jurisdictional fee schedule adjustment

Issues

Did the health care provider submit the medical bill in accordance with DWC guidelines?

Findings

The requestor is seeking additional reimbursement for implants that were part of inpatient procedure done November 19, 2019.

28 TAC §134.403 (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 the required certification statement was not included. The health care provider provided insufficient evidence to support the requirements of Rule 134.403 (g)(1)(A) was met. 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

Date

May 21, 2021

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.