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
Texas Regional Medical Center

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-21-1924-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 29, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TX workers compensation guidelines the expected reimbursement for DOS 11/6/2020 is $70,915.67."

Amount in Dispute: $35,305.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…all implantable medical device qualified items per regulations definition have been reimbursed at provider's submitted cost plus 10%, not to exceed $1,000 markup per bill item. All other items were not permanently implanted and do not meet the state's definition of an allowable implant."

Response Submitted by: FORESIGHT

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 6, 2020	C1713	$35,305.99	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 guidelines when seeking separate reimbursement of implants during outpatient hospital procedures.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
    - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 4915 – 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

Issues

What is the applicable rule for determining if the disputed services are eligible for reimbursement?

Findings

The requestor is seeking reimbursement for implants provided at the time of an outpatient surgery in November 2020.

DWC Rule 28 TAC §134.403 (g)(1) requires a facility or surgical implant provider billing separately for an implantable to include a certification of the amount billed that includes the 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 referenced above was not found.

The requestor has not met the required documentation of Rule 28 TAC §134.403 (g)(1) in seeking separate reimbursement of the implants.

No payment can be 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	[redacted] Medical Fee Dispute Resolution Officer	July 30, 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.