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
Baylor Surgical Hospital at TR

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-21-2156-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 23, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reconsider additional payment for Rev code 278/Implants which separate reimbursement was requested in Box 80 of UB-04 form, and implants are separately payable."

Amount in Dispute: $1,785.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… it is the carrier's position that it has already reimbursed the provider in accordance with the Medical Feed Guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 24, 2020	Outpatient Hospital Services	$1,785.79	$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:
    - 231 – Mutually exclusive procedures cannot be done on the same day/setting
    - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

Did the requestor meet the requirements when billing for separate reimbursement of implants?

Findings

The requestor is seeking additional reimbursement in the amount $1,785.79 for implants provided during an outpatient hospital procedure on November 24, 2020.

DWC Rule 28 TAC §134.403 (g) (1) (A) 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 insufficient evidence to support invoices that support the cost of the disputed items or the required certification.

The requestor did not meet the requirements of requesting separate reimbursement of implants. No reimbursement 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	August 16, 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.