TDI **Division of Workers' Compensation**

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Baylor Surgical Hospital at TR

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-21-2212-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 30, 2021

Requester's Position

In accordance with the TX WC fee schedule implants should be paid at manual cost + 10%.

Amount in Dispute: $1,200.60

Respondent's Position

…Requestor is not owed separate reimbursement for the implantables for failure to provide the documentation required by DWC Rule 134.403(g)(1).

Response Submitted by: Downs Stanford

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2020	C1713	$2145.00	$0.00
September 23, 2020	C1762	$135.30	$0.00
September 23, 2020	C1781	$2860.00	$0.00
Total		$1,200.60	$0.00

Findings and Decision

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the reimbursement guidelines for outpatient hospital services.

3. Neither part presented explanation of benefits for the services in dispute.

Issues

1. What rule applies for determining reimbursement for the disputed services?

Findings

1. The requestor submitted a copy of the reconsideration submitted for the disputed services where they indicate the implant invoices were attached. Review of the submitted documentation found no invoices.

   DWC Rule 28 TAC 134.403(g)(1) requires that a facility billing separately for an implantable shall include the billing certification and the actual cost for the implantable.

   Neither of the required elements were found. No additional 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. Although all the evidence in this dispute may not have been discussed, it was considered.

DWC finds the requester has not established that payment is due. As a result, the amount ordered is $0.

Order

Under Texas Labor Code §413.031, it is ordered that the requester is entitled to $0 additional reimbursement for the disputed services.

Authorized Signature

		September 1, 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed 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.