TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgicare of Plano

Respondent Name
Accident Insurance Fund of America

MFDR Tracking Number
M4-22-0390-01

Carrier's Austin Representative
Box Number 06

DWC Date Received
October 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 19, 2021	ASC Services	$1,057.08	$0.00

Requestor's Position

"According to Texas Workers Compensation Rule 134.402, 'Implantable devices are reimbursed at the providers cost plus 10% up to $1,000.00 per item or $2,000.00 per case.'"

Amount in Dispute: $1,057.08

Respondent's Position

"Upon review, it is the Carrier's position that the re-validation costs fo rthe implatns and the ture billing costs are less than the amount paid, therefore no adidiotnal moines will be paid as we believe they are not owed."

Response Submitted by: United Heartland

Findings and Decision

Authority

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).

Statutes and Rules

1. 28 Texas Administrative Code §133.10 sets out the procedures for completing medical bills.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 8 – The supploy charge was disallowed as it was not adequately identified. Please resubmit with invoice.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending futher payment to be made for the above noted procedure code.
- 11 – The recommended allowance for the supply was based on the attached invoice.
- W3 – Additional payment made on appeal/reconsideration.
- P12 – Workers' compensation jurisdictional ee schedule adjustment.
- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Is Baylor Surgicare of Plano entitled to additional reimbursement?

Findings

1. Baylor Surgicare of Plano is seeking an additional reimbursement of $537.08 for HCPCS code C1713 and $520.00 for HCPCS code C1763.

   Per explanation of benefits dated June 8, 2021, submitted with the dispute indicates that Accident Insurance Fund of America paid the full amount billed for the charges in question. No additional reimbursement can be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 20, 2021 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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.