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 Surgical Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-22-0746-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
December 17, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 30, 2021	C1713	No amount listed on DWC60	$0.00
June 30, 2021	C1781	No amount listed on DWC60	$0.00
June 30, 2021	29827	0.00	$0.00
	Total	$491.67	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "According to TX workers compensation fee schedule the expected reimbursement for DOS 6/30/2021 is $14,599.58. Please note that implants should be reimbursed at annual cost plus 10%, Previous payment received totaled $14,067.91 leaving a balance of $491.67."

Amount in Dispute: $491.67

Respondent's Position

The Carrier contends the Provider is not entitled to additional reimbursement.

Response Submitted by: Travelers

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

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

Denial Reasons

The insurance carrier reduced 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
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly

Issues

1. What rule applies for determining reimbursement of implants?

Findings

1. The requestor is seeking additional reimbursement of implants provided as part of an outpatient hospital surgical procedure in June of 2021.

   DWC Rule 28 TAC §134.403 (g) (1) states in pertinent part 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 for the implantable. Review of the submitted documentation found insufficient evidence to support the requestor included the required billing certification. No additional payment is 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	January 21, 2022 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.