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
Memorial Hermann Specialty Hospital

Respondent Name
Manufacturers Alliance Insurance Co

MFDR Tracking Number
M4-22-0910-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 29, 2021	C1713	$1,753.83	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Per TX workers compensation guidelines the expected reimbursement for implants $5,373.45 in accordance with the TX WC guidelines, when separate reimbursement is requested in box 80 of UB04 implants should be paid at manual cost + 10%. Previous payment received total $7,301.57. Please review and submit remaining balance due of $1,753.83."

Amount in Dispute: $1,7853.83

Respondent's Position

The Austin carrier representative for Manufacturers Alliance Ins Co is Flahive Ogden and Latson. The representative was notified of this medical fee dispute on January 25, 2022

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- Workers' compensation jurisdictional fee schedule adjustment

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of implants provided as part of an outpatient hospital surgery in January 2021. The insurance carrier reduced the payment based on the applicable DWC fee guideline.

   DWC Rule 134.403 (g) states in pertinent part, implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   Review of the submitted itemized statement, invoice to support cost, and medical documentation, indicates the utilization of seven implants with a cost each of $470.08 for a

total cost of $3,290.06 plus the 10 percent add on of $329.06 for a total reimbursement of $3,619.62.

2. The total recommended reimbursement for the disputed services is $3,619.62. The insurance carrier paid $3,619.62. 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	April 13, 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.