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
Grapevine Surgicare

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-22-0965-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
January 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 1, 2021	29888	$0.00	$0.00
April 1, 2021	29881	$0.00	$0.00
April 1, 2021	C1713	$480.03	$0.00
April 1, 2021	C1762	$1759.73	$0.00
	Total	$5675.00	$0.00

Requestor's Position

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

Amount in Dispute: $5675.00

Respondent's Position

The Austin carrier representative for TASB Risk Mgmt Fund is Burns Anderson Jury & Brenner. The representative was notified of this medical fee dispute on February 1, 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 §134.402 sets out the billing requirements of ambulatory surgical center medical bills.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 353 – This charge was reviewed per the attached invoice
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts payment and contractual
- 59 – Processed based on multiple or concurrent procedure rules
- 615 – Payment for this service has been reduced according to the Medicare multiple surgery guidelines
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- 95 – Plan procedures not followed
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 1200 – The was no UR Procedure/Treatment request received

Issues

1. Did the requestor meet the requirements of requesting separate implant reimbursement?

Findings

1. The requestor is seeking additional reimbursement of implants as part of a surgery performed in an ambulatory surgical center on April 1, 2021. DWC Rule 28 TAC §134.402 (g)(1)(B) states in pertinent parts the facility or surgical implant provider requesting reimbursement for the implantable shall include with the billing a certification that the amount billed represents the actual cost for the implantable. The certification shall include the following sentence: "I herby certify under penalty of law that the following is the true and correct actual cost to the best of

my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable…

Review of the submitted "Implant Cost Certification" was not signed or dated.

The requirements of applicable Rule is not met. 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

		May 18, 2022
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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.