

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

North Central Surgical
Hospital

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-22-1058-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

February 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 6,, 2021	C1713	\$1,331.00	\$0.00
October 6, 2021	L8699	\$1,540.00	\$0.00
	Total	\$2,871.00	\$0.00

Requestor's Position

Requestor did not submit a position statement but did submit a copy o their reconsideration that states, "According to TX workers compensation fee schedule the expected reimbursement for DOS 10/7/2021 is \$43,412.64. Please note that implants should be reimbursed at manual cost plus 10%. Previous payment received totaled \$41,879.65 leaving a balance of \$1,732.99."

Amount in Dispute: \$2,871.00

Respondent's Position

Our position is that no payment is due.

Response submitted by: Texas Mutual

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

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 97 – 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

Issues

1. What rule applies when determining reimbursement for implants?

Findings

1. DWC Rule 28 TAC §134.403 (g) (1) states 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 (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." Review of the submitted documentation found insufficient evidence to support the required certification was included. 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

_____	_____	February 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 electrónico CompConnection@tdi.texas.gov.