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
HERITAGE PARK SURGICAL HOSPITAL

Respondent Name
AIU INSURANCE CO

MFDR Tracking Number
M4-22-2423-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 28, 2021	Revenue Code 278	$849.02	$0.00
	Total	$849.02	$0.00

Requestor's Position

According to TX workers compensation fee schedule the expected reimbursement for DOS 12/28/2021 is $24,605.33. Please note that implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $23,756.30 leaving a balance of $849.03. Please reprocess and remit payment for remaining balance due.

Amount in Dispute: $849.02

Respondent's Position

The provider filed a DWC-60 seeking medical fee dispute resolution for a date of service December 28, 2021. The provider has identified the CPT code of 111-278. The provider claims to have billed $9,339.02 and was reimbursed the amount of $8,490. The provider is seeking additional reimbursement of $849.02. The total amount billed was $55,733.34. The total amount reimbursed was $23,756.30.

Response Submitted by: Flahive Ogden & Latson

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 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.

Denial Reasons

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

- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation we find our original review to be correct. Therefore, no additional allowance appears to be warranted
- 193 – Original payment decision is being maintained. Upon review it was determined that the claim was processed properly
- P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payment policies

Issues

1. Is the requestor entitled to additional payment for implants in dispute?

Findings

1. The requestor in dispute is seeking reimbursement for implants billed under revenue code 278 in the amount $8,490.00. The requestor's total charges billed to the insurance carrier is $55,733.34 for date of service December 28, 2021.

Review of the explanation of benefits provided by both parties supports that a payment for the implants in dispute was reimbursed in the amount of $8,490.00. The insurance carrier reimbursed the requestor a total of $23,756.30.

Therefore, DWC finds 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	August 5, 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.