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
Amtrust Insurance Co

MFDR Tracking Number
M4-22-2510-01

Carrier's Austin Representative
Box Number17

DWC Date Received
July 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 12, 2021	C1713	$440.36	$0.00
	Total	$440.36	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $440.36

Respondent's Position

"Total C1713 implant recommended allowance with net invoice cost = $3,543.50 + 10% (per State Regs) = $3,898.00. Provider was paid in full for these charges. Provider was paid per Texas State Statutes of "cost + 10%" and nothing further is due and owing for this line."

Response submitted by: Foresight

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 billing and reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 131 – Claim specific negotiated discount
- 353 – This chare was reviewed per the attached invoice
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup.
- 45 – Charge exceeds fee schedule maximum allowable or contracted legislated fee arrangement
- P12 – Workers' compensation jurisdiction fee schedule adjustment
- PHO – Surgical implant charges reviewed separately by Foresight Medical

Issues

1. Did the requestor meet the requirements of Rule 134.403?

Findings

1. Requestor is seeking additional reimbursement of implants provided during an outpatient hospital surgical procedure. DWC Rule 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 (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 of the required statement. No additional payment 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	September 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.