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
RESOLUTE HEALTH SYSTEM

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSAU

MFDR Tracking Number
M4-23-0122-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
September 12, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 24, 2022	Hospital Outpatient Service (Implants Rev Code 278)	$3,174.50	$0.00

Requestor's Position

We have received payment in the amount of $11, 585.82 with $00.00 as patient responsibility. We are requesting an additional $3,174.50 ... Revenue Code 278 charges are reimburse as charges in service type $12,087.18 exceeds threshold of $3,000 then cost + less of 10 percent of $1,000 per item not to exceed $2,000.00 per admission with reimbursement of $7,380.16. OPSurg Implants greater than $3,000 are payable at 130% of Standard Medicare OPPS pricing in the amount of $7,380.16.

Amount in Dispute: $3,174.50

Respondent's Position

We have again reviewed payment for the services of March 24, 2022, by Resolute Health System and determined that reimbursement was issued according to the guidelines provide by the Texas Medical Fee Schedule as the provider did not request for reimbursement for implants on original submission. No additional payment is due.

Response Submitted by: Liberty Mutual Insurance

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 §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

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

- 4915 – The charge for the services represented by the code is included/bunlded into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excuded from payment
- 193 – Original payment decision nis being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon, review, it was determined that this claim was processed properly

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor in dispute is requesting reimbursement for billed revuene code 278 Implants. However, the requestor did not request reimbursement for implants in accordance with

   28 Texas Administrative Code §134.403 (f)(1)(B).

   Therefore, no reimbursement is not 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

[redacted] [redacted]

Signature | Medical Fee Dispute Resolution Officer | October 7, 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.