TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-23-1184-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
January 25, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 29, 2022	C1713	$3,812.59	$0.00
August 29, 2022	C1762	$3,080.00	$0.00
	Total	$6,892.59	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. The did submit a copy of their reconsideration that states in pertinent part, "According to TX workers compensation fee schedule the expected reimbursement for DOS 8/29/2022 is $14,989.15. Please note that implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $12,450.20. Please reprocess and remit payment for remaining balance due."

Amount in Dispute: $6,892.59

Respondent's Position

"The EOB processed on 10/11/2022 states, "The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment of the payment status indicator determines the service is packed or excluded for payment." The EOB also denies the services for, "Payment adjusted because the benefit for this service is

included in the payment/allowance for another service/procedure that has already been adjudicated. On 11/17/2022, the request for reconsideration was processed and the denial upheld.

Response submitted by: Ricky D. Green, PLLC

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 required elements when separate reimbursement of implants is requested.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Did the requestor meet the required documentation requirements when requesting separate reimbursement of implants?

Findings

1. The requestor is seeking reimbursement of implants rendered as part of an outpatient hospital surgery. The insurance carrier denied the service as packaged.

   DWC Rule 238 TAC 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 the required certification was not included with information submitted by the requestor. 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

Signature	Medical Fee Dispute Resolution Officer	March 7, 2023 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.