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
Graphic Arts Mutual Insurance Co

MFDR Tracking Number
M4-24-0285-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
October 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 2, 2023	C1713	$1,567.00	$0.00
February 2, 2023	C1781	$2,970.00	$0.00
	Total	$4,357.50	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR) but did submit a document titled "Reconsideration" addressed to Texas Department of Insurance. This document states, "According to TX workers compensation fee schedule the expected reimbursement for DOS 2/02/2023 is $12,910.54. Please note that separate reimbursement was requested in Box UB-04 form for implants, and should be reimbursed at manual cost plus 10%."

Supplemental response November 1, 2023.

We received partial payment for MDR# M4-24-0285-01. Bill was processed by Foresight Medical and payment in the amount of $4,125.00 paid on 10/18/2023, CK# 28817. However, we still show a balance owed $406.28.

Amount in Dispute: $4,357.50

Respondent's Position

"The bill was processed by Foresight Medical, who issues payment on 8/02/2023 with check #28278 but it has not cleared. The check was mailed to the address provided on the bill. …Foresight stopped this outstanding check & payment reissued 10/18/2023 on check #28817 in the amount of $4125.00."

Response submitted by Utica National Insurance Group

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 192 – Non standard adjustment code from paper remittance advice.
- 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.
- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking payment of implants rendered during an outpatient hospital surgical procedure in February of 2023. The insurance carrier reduced the payment based on the workers' compensation fee schedule. A replacement check was sent and acknowledged but the requestor wished to continue with MFDR.

   DWC Rule 28 TAC 134.403 (g) (1) states,

   (1) 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 billing certification was sent to MFDR. 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 14, 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.