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
Texas Mutual Insurance Company

MFDR Tracking Number
M4-24-2292-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
June 18, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 23, 2023	278 SUPPLY/IMPLANTS	Left blank	$0.00
October 23, 2023	360 OR SERVICES	Left blank	$0.00
October 23, 2023	360 OR SERVICES	Left blank	$0.00
October 23, 2023	370 ANESTHESIA	Left blank	$0.00
October 23, 2023	420 PHYSICAL THERAPY	Left blank	$0.00
October 23, 2023	424 PHYS THERP/EVAL	Left blank	$0.00
October 23, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
October 23, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
October 23, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
October 23, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
October 23, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
October 23, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00
October 23, 2023	636 DRUGS/DETAIL CODE	Left blank	$0.00

October 23, 2023	710 RECOVERY ROOM	$0.00	$0.00
	Total	$6,509.00	$0.00

Requestor's Position

"Resolute Health Hospital is requesting TEXAS MUTUAL review implantable TDI-DWC rules; updated claim and reprocess and issue the additional $6,664.83 due on Outpatient Implantables."

Amount in Dispute: $6,509.00

Respondent's Position

"Texas Mutual received the original bill and processed it at 200% of APC/OPPS rates as no request for implants was indicated in box 80 of the UBO4 form as required by rule 134.403(f)(1)(B). Additionally, no invoice showing the cost of the implants has been provided. Our position is that no additional payment is due."

Response Submitted by: Texas Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §133.10 sets out the requirements for requesting implant reimbursement.

Denial Reasons

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

- 692,225 – No invoice provided for implant reimbursement. Separate implant reimbursement not requested on UB 04.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3, 350 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 892 – Denied in accordance with DWC rules and/or medical fee guidelines including current CPT code descriptions/instructions.
- 767 – Paid per O/P FG at 200% implants not applicable or separate reimbursement (with cert) not requested per rule 134.403 (g)
- 728 – This bill was reviewed/denied in accordance with your Coventry contract for questions please call 1-800-938-6624.
- DC4 – No additional reimbursement allowed after reconsideration for information call (888) 532-5246.
- 217, 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 371 – This hospital outpatient allowance was calculated according to the OPPS payment for this service.

Issues

1. Did the requestor submit for implant reimbursement per Division guidelines?

Findings

1. The requestor states in their request for reconsideration that separate reimbursement of the implants rendered during outpatient procedure in October of 2023 should be reimbursed.

   DWC Rule 133.10 (2)(QQ) states, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."

   Review of the submitted medical bill found box 80 did not contain a request for separate implant reimbursement. 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.

The DWC finds the requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 10, 2024 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, 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.