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
American Casualty Co of Reading PA

MFDR Tracking Number
M4-25-0102-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
September 29, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 17, 2024	C1778	$19,250.00	$0.00
	Total	$19,250.00	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dated August 26, 2024 that states, "Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: $19,250.00

Respondent's Position

"The Carrier asserts no additional allowable is due as reflected on the issued and attached EORs."

Response submitted by Law Office of Brian J. Judis

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 11 – The recommended allowance for the supply was based on the attached invoice.
- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of an outpatient hospital surgery whereas an implant was used.

   DWC Rule 28 TAC §134.403 (g) states, "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

   Review of the submitted medical bill and itemized statement found the following.

   - "Leads Proclaim Plus 5 DU" as identified in the itemized statement and labeled on the invoice as "Proclaim Plus 5 Dual Octrode System" with a cost per unit of $20,250.00.

   The total net invoice amount (exclusive of rebates and discounts) is $20,250.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,000.00. The total recommended reimbursement amount for the implantable items is $21,250.00.

2. The total recommended reimbursement for the disputed services is $21,250.00. The insurance carrier paid $21,250.00. Additional payment 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 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

		October 29, 2024
Signature	Medical Fee Dispute Resolution Officer	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.