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

Requester Name
Doctors Hospital at Renaissance

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-21-2175-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 27, 2021

Requester's Position

The requestor included a copy of their request for reconsideration in which they state, "According to TWCC guidelines, Rule 134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $16,929.61

Respondent's Position

It is the carrier's position that the provider is not entitled to any additional reimbursement.

Response Submitted by: Flahive, Ogden & Latson

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 11, 2020	Outpatient Hospital Service	$16,929.61	$0.00
	Total	$16,929.61	$0.00

Findings and Decision

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).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
    - 906 – In accordance with clinical based coding edits component code of comprehensive medicine, evaluation and management services (90000-99999) has been disallowed

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered in June 2020. DWC Rule 28 TAC §133.307(c)(1) states in pertinent part a request for medical fee dispute that does not involve issues of compensability, extent of injury, liability, medical necessity, or a refund shall be filed no later than one year after the date(s) of service in dispute.

   The date of the service in dispute is June 11, 2020. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 27, 2021.

   This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in above.

   DWC concludes that the requestor has failed to timely file this dispute with DWC's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Although all the evidence in this dispute may not have been discussed, it was considered.

DWC finds the requester has not established that payment is due. The amount ordered is $0.

Order

Under Texas Labor Code §413.031, it is ordered that the requester is entitled to $0 additional reimbursement for the disputed services.

Authorized Signature

		August 25, 2021
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 512-804-4812.