



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Grapevine Surgicare

**Respondent Name**

Old Republic Insurance Co.

**MFDR Tracking Number**

M4-22-0331-01

**Carrier's Austin Representative**

Box Number 44

**DWC Date Received**

October 15, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 10, 2021	CPT 29827	\$2,342.83	\$0.00
	CPT 29822	\$531.17	\$0.00
	CPT 29826	\$0.00	\$0.00
	HCPCS C1713	\$0.00	\$0.00
	Total	\$960.00	\$0.00

### Requestor's Position

**Original Statement:** The following is a breakdown of how this claim should have processed:

CPT 29827 allows \$6779.26 (pays at 100%) = \$6779.26

CPT 29822 allows \$1537.04 (pays at 50%) = \$1537.04

Claim Allowed Total= \$8316.30

Less payment made of \$7356.30

We are owed an additional payment of \$960.00

**Supplemental Statement:** We have received & posted the additional payment but the claim is still not paid per the fee schedule allowed amount.

We show the allowed amount to be \$10449.21

To date the carrier has paid \$8316.30

**Amount in Dispute:** \$960.00

## **Respondent's Position**

The payment went out on 11/16/21 but has not been cashed to date.

**Response Submitted by:** White Espey, 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.

### Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Additional payment made on appeal/reconsideration.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- OA – The amount adjusted is due to bundling or unbundling of services.

### Issues

1. Is Grapevine Surgicare entitled to additional reimbursement?

### Findings

1. Grapevine Surgicare is seeking additional reimbursement for ambulatory surgical services performed on March 10, 2021.

The insurance carrier submitted evidence that supports an additional payment of \$960.00, the amount requested in this dispute, on or about November 16, 2021. No additional reimbursement 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

_____	_____	January 5, 2022
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).