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
The Surgical Center

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-22-1231-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 23, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 15, 2016	29880 LT	$3,600.00	$0.00
	Total	$3,600.00	$0.00

Requestor's Position

The requestor did not submit a position statement but submitted a request for reconsideration dated July 16, 2019, that states, "We received a 0 payment from Gallagher Bassett stating that we needed to have our Provider State License number listed in box 57 and also is box 76. The has been added per your request. Please review the claim and process."

Amount in Dispute: $3,600.00

Respondent's Position

The Austin carrier representative for American Zurich Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on March 1, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available.

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

- 16 – Claim/service lacks information or has submission/billing error(s).
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Alabama to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action.

   The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration.

   The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307.

   Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules

2. DWC 28 TAC §133.307(c)(1) states in pertinent part, a requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   (B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The requestor supported a refund was issued to BC/BS of Alabama on April 25, 2019.

However, the request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on February 23, 2022. This date is beyond 60 days after the date of receipt of the refund. The requestor has waived their right to medical fee dispute.

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

		June 7. 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. 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.