

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Resolute Health System

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-22-2604-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

August 11, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 15, 2021	250		\$0.00
July 15, 2021	278/X1713		\$0.00
July 13, 2021	300/C9830/CS		\$0.00
July 13, 2021	300/80048		\$0.00
July 13, 2021	300/85027		\$0.00
July 13, 2021	300/U0002		\$0.00
July 15, 2021	360/26350/F7		\$0.00
July 15, 2021	360/64912/RT		\$0.00
July 15, 2021	370		\$0.00
July 15, 2021	636/J1100		\$0.00
July 15, 2021	636/J2250		\$0.00
July 15, 2021	636/2704		\$0.00
July 15, 2021	636/2795		\$0.00
Total		Left blank by requestor	\$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Per the terms of our agreement governing Texas Mutual Insurance Co effective

01/01/20, our expected contract allowable is based on: Fee/Rate Schedule. Based on this/these service(s), the expected reimbursement amount is \$11,444.45."

Amount in Dispute: This field left blank by requestor.

Respondent's Position

"The disputed date of service 7/13/2021 to 7/15/2021 is greater than one year from the TDI/DWC date-stamp of 8/11/2022, listed on the requestor DWC60 packet and has waived its right to DWC MDR. Our position is that no payment is due."

Response submitted by:

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.
2. 28 TAC §xxx sets out the billing requirements of professional medical claims.

Denial Reasons

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

- A16 – The reimbursement for health care services are subject to Workwell, TX Contracts, a certified WC HCN (INS Code Ch 1305)
- 131 – "Claim specific negotiated discount
- 97 – The benefit for this service is included in the payment/allowance or another service/procedure that has already been adjudicated
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 350 – In accordance with TDI-DWC Rule 134.804,, this bill has been identified as a request for reconsideration.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 728 – This bill was reviewed/denied in accordance with your Coventry contract.

- 767 – Paid per O/P at 200%; Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G).

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. What is the complaint process for health care provider to a Health Care Network?

Findings

1. DWC Rule 28 TAC §133.307(c)(1) states:

"Timeliness. 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.

1. 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 date of the service in dispute is July 13 -15, 2021. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on August 11, 2021.

Review of the submitted documentation found insufficient evidence to support an exception to the time limit for requesting MFDR. No payment can be recommended.

2. The complaint process outlined in Texas Insurance Code, Subchapter I, §1305.401 - §1305.405 may be the appropriate administrative remedy to address fee matters related to health care certified networks.

Medical fee disputes may be filed through the Texas Department of Insurance complaint resolution process found at <https://www.tdi.texas.gov/wc/ci/wccomplaint.html>, if the health care provider is not satisfied with the outcome of the network complaint process.

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.

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

_____ Signature	_____ Medical Fee Dispute Resolution Officer	September 6, 2022 Date
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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.