

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
 Providence Memorial
 Hospital

Respondent Name
 City of El Paso

MFDR Tracking Number
 M4-22-2629-01

Carrier's Austin Representative
 Box Number 19

DWC Date Received
 August 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 1, 2021	0250	\$524.00	\$0.00
July 1, 2021	0278	\$18021.00	\$0.00
July 1, 2021	0300	\$217.00	\$0.00
July 1, 2021	0360	\$8706.00	\$0.00
July 1, 2021	0636	\$668.52	\$0.00
July 1, 2021	0710	\$6202.00	\$0.00
Work Comp Adjustments		-31462.37	
Total		\$4619.15	\$0.00

Requestor's Position

"The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Claims Administrator, but the bill was underpaid."

Amount in Dispute: \$4,619.15

Respondent's Position

"It is our position that payment issued was correct and no additional reimbursement would be

due.

Response submitted by: Claims Administrative Services, Inc.

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

- P12 – Workers Compensation jurisdictional fee schedule adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 350 – Bill has been identified as a request for reconsideration or appeal
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup

Issues

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

Findings

1. 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.

(A) 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 1, 2021. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on August 16, 2022.

Review of the submitted documentation found insufficient evidence to support an exception to the request for medical fee dispute resolution filing deadline of one year from the date of service. No additional payment 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 requestor 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

Signature

Medical Fee Dispute Resolution Officer

August 31, 2022

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 electrónico CompConnection@tdi.texas.gov.