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
BAPTIST HEALTH SYSTEM

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-23-0426-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
October 11, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 7, 2022	Inpatient Hospital Service	$1,217.78	$0.00

Requestor's Position

Based on this/these service(s), the expected reimbursement amount is $47,991.69.

We have received payment in the amount of $46,773.91 with $0.00 as patient responsibility. We are requesting an additional $1,217.78.

In additional to the contract, the expected reimbursement is 100% of the Medicare allowable for DRG billed 853, in the amount of $47,991.69.

Amount in Dispute: $1,217.78

Respondent's Position

The provider believes additional reimbursement should be awarded for Revenue Code 360. The provider billed $67,205.00 for the service and the Respondent paid $14,309.57. The provider believes an additional $1,217.78 should be paid. However, the fee guidelines do not support additional reimbursement.

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 Texas Administrative Code §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:

- 4896 – Made per medicare IPPS methodology, with the applicable state markup
- P12 – Workers compensation jurisdicitional fee schedule adjustment
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered

Issues

1. Did the requestor submit medical bills in accordance with 28 Texas Administrative Code §133.307?

2. Is requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 (c)(2)(J) states :

   (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include:

   (J) a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills);

   Review of the submitted documentation finds the requestor did not provide any medical bills with the DWC-060 dispute request.

2. The requestor is not entitled to reimbursement as the request was not filed in accordance with

28 Texas Administrative Code §133.307 (c)(2)(J).

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

Signature	Medical Fee Dispute Resolution Officer	January 6, 2023 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.