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
Wadley Regional Medical Center

Respondent Name
Indemnity Insurance Co. of North America

MFDR Tracking Number
M4-23-0747-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
November 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 10, 2022	Outpatient Hospital Services	$6,523.40	$0.00

Requestor's Position

CPT Code 29828 remains underpaid after appeal.

Amount in Dispute: $6,523.40

Respondent's Position

Although the Claimant lives in Texas, the Claimant was injured while working in Arkansas, while working for his Arkansas-based employer. The Claimant elected to receive benefits under the Arkansas workers compensation laws, and the Carrier has accepted the claim by filing the attached Form AR-2. Consequently, this medical treatment was authorized and the bill was reimbursed under the workers' compensation laws of Arkansas. As this is an Arkansas workers compensation claim under the jurisdiction of Arkansas Workers' Compensation Commission, the Texas Division of Workers' Compensation has no jurisdiction over this dispute.

Response Submitted by: Constitution State Services

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.

2. TLC 406, Subchapter D regulates extraterritorial coverage.

Denial Reasons

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

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 829 – No payment is being recommended for this procedure or service. The date of service is after the claim-closed date.
- 8855 – A provider may request reconsideration of its adjusted and/or disputed bill within 30 days of receipt of this Explanation of Reimbursement based on Rule 30. Sect. II.B
- 876 – Reimbursement equals the amount billed.
- 5416 – A copy of the invoice for implant is required before payment can be considered.
- 78 – The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
- 76 – Bill is greater than surgical service fee.
- 237 – The recommended allowance is based on usual, customary and reasonable rates for this geographical area.

Issues

1. Does the Medical Fee Dispute Resolution (MFDR) office have jurisdiction to review this dispute?

Findings

1. Texas Labor Code §406.075 (a) states that "An injured employee who elects to pursue the employee's remedy under the workers' compensation laws of another jurisdiction and who recovers benefits under those laws may not recover under this subtitle." The division has good cause to believe that the disputed health care relates to the injured employee's claim for benefits under work injury laws for the state of Arkansas.

For this reason, the division finds that MFDR does not have jurisdiction to review this 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.

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 14, 2023
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.