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
MUELLER SURGERY CENTER LLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-23-0854-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
December 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 03, 2021	Code 21315 and L8699	$3,500.49	$0.00
	Total	$3,500.49	$0.00

"In regards to our fee dispute against Texas Mutual, please note that this is the not the 1st dispute we have filed against Texas Mutual in the past year. Texas Mutual did process and pay most of our claim for [injured worker]. There are 2 codes that are still unpaid, CPT Code 21315 and L8699."

Amount in Dispute: $3,500.49

Respondent's Position

"The disputed date of service 12/03/2021 to 12/03/2021 is greater than one year from the TDI/DWC date-stamp of 12/13/2022, 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: Texas Mutual Workers' Compensation Insurance

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:

- CAC-131 claim specific negotiated discount
- CAC-P5 based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement
- CAC-W3 In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- DC3 – Additional reimbursement allowed after reconsideration. For Information Call (888) 532-5246
- 426 – Reimbursed to fair and reasonable
- 350 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal
- CAC-193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- CAC-P12 – Workers Compensation Jurisdictional fee schedule adjustment
- CAC-97 – The benefit for this service in included in the payment/allowance for another service/procedure that has already been adjudicated
- DC4 – No additional reimbursement allowed after reconsideration. For information call (888) 532-5246
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 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 or appeal

Issues

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

Findings

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

   Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR 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.

   The date of the services in dispute is December 03, 2021. The request for medical fee dispute resolution was received on December 13, 2022. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute; consequently, the requestor has waived the right to medical fee dispute resolution.

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 that no 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

[redacted]		February 24, 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.