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
TX Health Surgery Park Hill

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-23-1034-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 6, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 18, 2022	29827	$4527.08	$0.00
April 18, 2022	64415	$321.59	$0.00
April 18, 2022	76942	$0	$0.00
April 18, 2022	29826	$0	$0.00
April 18, 2022	C1713	$1402.50	$0.00
April 18, 2022	C1713	$707.30	$0.00
April 18, 2022	C1713	$833.80	$0.00
April 18, 2022	C1713	$833.80	$0.00
April 18, 2022	C1762	$1964.60	$0.00
April 18, 2022	A4605	$115.50	$0.00
	Total	$6179.09	$0.00

Requestor's Position

The requestor did not submit a position statement with their request for MFDR but did submit a copy of their reconsideration that states, "Per review of contract, total allowed for this claim should have been $6939.62 but claim only allowed $4527.07. Please review and submit in writing your findings and if additional payment is warranted."

Amount in Dispute: $6179.09

Respondent's Position

"The provider did not fully comply per Rule 133,.307(J)… Our position is that no payment is due."

Response submitted by: Texas Mutual

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 or denied the disputed service(s) with the following claim adjustment codes.

- P12 – Workers; compensation jurisdictional fee schedule adjustment
- 236 – This billing code is not compatible w3ith another billing code provided on the same day according to NCCI or Workers' Compensation state regulations/fee schedule requirements
- 662 – Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package
- 764 – Reimbursed per ASC FG at 153%. Separate reimbursement for implantables (including signed certification was requester per Rule 134.402(G)
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

Issues

1. Did the requestor submit this request for MFDR with the required documentation?

Findings

1. The requestor Is seeking additional reimbursement of services rendered in April of 2022. The requestor submitted a request for MFDR but did not include a copy of the medical bill that was adjudicated by the insurance carrier.

   DWC Rule 133.307(2) states, "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 found insufficient evidence of the required medical bill that supports the services listed on the DWC60. No 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 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	March 31, 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.