



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Crescent Medical Center

**Respondent Name**

New Hampshire Insurance Co.

**MFDR Tracking Number**

M4-23-1183-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

JANUARY 25, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
11/24/2020-11/27/2020	DRG 470	\$1,483.34	\$0.00
11/24/2020-11/27/2020	REV 0278 IMPLANTS	\$502.50	\$0.00
<b>Total</b>		\$1,985.84	\$0.00

### Requestor's Position

Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

**Amount in Dispute:** \$1,985.84

### Respondent's Position

"We are in receipt of the above captioned medical fee dispute resolution. Payment has been made for \$502.50. We have attached the EOB."

**Response Submitted by:** New Hampshire Insurance Co.

## 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 Medical Fee Dispute Resolution requests.

### Denial Reasons

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

- 790 – This charge was reimbursed in accordance with the Texas Medical fee Guideline.
- AA3 – Surgical implants are reviewed separately by Carisk.
- PP1 – Pricing applied via Prime Health Services.
- 885 – Review of this code has resulted in an adjusted reimbursement.
- 468 – Reimbursement is based on the Medical Hospital Inpatient Prospective Payment System Methodology.
- 131 – Claim specific negotiated discount.
- P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment.
- P13 – Payment reduced or denied based on Workers' Compensation Jurisdictional Regulations or Payment Policies.

### Issues

1. Has Crescent Medical Center waived its right to medical fee dispute resolution?

### Findings

1. Crescent Medical Center is seeking additional reimbursement for inpatient hospital services on dates of service November 24, 2020 through November 27, 2020. The medical fee dispute request form DWC060 was received on January 25, 2023.

28 Texas Administrative Code(TAC) §133.307 (c) sets out the timely filing procedures for Medical Fee Dispute Resolution requests. TAC §133.307 (c) 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"

Review of the submitted documentation finds that:

- The request for medical fee dispute resolution was received in MFDR on January 25, 2023.
- The disputed dates of service are November 24, 2020 to November 27, 2020
- The disputed services do not involve issues identified in 28 TAC §133.307(c)(1)(B)
- One year from November 27, 2020, is November 27, 2021.
- The requestor did not file this dispute with the division within the one-year deadline set out in 28 TAC §133.307.

The division finds that Crescent Medical Center is entitled to \$0.00 additional reimbursement.

### 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.

The division finds the requester has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 TAC §133.307(c)(1) and (c)(1)(A).

## **Order**

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

### **Authorized Signature:**

_____	_____	03/08/2023
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](http://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](mailto: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.tas.gov](mailto:CompConnection@tdi.tas.gov).