

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Crescent Medical Center

**Respondent Name**

AmTrust Insurance Co

**MFDR Tracking Number**

M4-23-1214-01

**Carrier's Austin Representative**

Box Number 17

**DWC Date Received**

JANUARY 26, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
9/4/2020-9/8/2020	DRG 354	\$0.00	\$0.00
9/4/2020-9/8/2020	IMPLANTS REV 0278	\$6,768.85	\$0.00
<b>Total</b>		\$6,768.85	\$0.00

### Requestor's Position

"Our expected reimbursement was \$21,018.12. You paid \$18,568.86. Attached is the Medicare Fee Schedule and our records. Please reprocess and pay the additional \$2449.26"

**Amount in Dispute:** \$6,768.85

### Respondent's Position

"Medical Fee Dispute Resolution received Requestor's DWC-60 on 1/26/2023, as evidenced by the date stamp on the DWC-60. The dates of service at issue in this matter are 9/04/2020-9/08/2020. Therefore, Respondent requests Medical Fee Dispute Resolution enter a Findings and Decision stating Requestor waived their right to dispute resolution as the request was not filed within one year of the date of service."

**Response Submitted by:** AmTrust 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:

- 131 - Claim specific negotiated discount.
- 350 - Bill has been identified as a request for reconsideration or appeal.
- 353 - This charge was reviewed according to the submitted invoice and documentation.
- 45 - Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
- PHO - Surgical implant charges reviewed separately by Foresight Medical.
- W3 - In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration.

### Issues

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

### Findings

1. Crescent Medical Center is seeking additional reimbursement for IMPLANTS REV 0278, on dates of service September 4, 2020 through September 8, 2020. The medical fee dispute request form DWC060 was received on January 26, 2023. Pursuant to 28 Texas Administrative Code §133.307 (c) which sets out the timely filing procedures for Medical Fee Dispute Resolution requests, the division finds that Crescent Medical Center is not entitled to 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.

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

03/02/2023  
\_\_\_\_\_  
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](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.texas.gov](mailto:CompConnection@tdi.texas.gov).