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
North Central Baptist Medical Center

Respondent Name
Tokia Marine America Insurance Co.

MFDR Tracking Number
M4-23-1982-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
April 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
02/09/2022	27380	$518.16	$0.00

Requestor's Position

*Note that this position statement is taken from Requester's Reconsideration Request.
"We have received payment in the amount of $11,573.54 with $00.00 as patient responsibility. We are requesting an additional $518.16. Pursuant to the contract, page 38, Texas Department of Insurance Division of Worker's Compensation; All OP Surgery charges are payable at 200% of Standard Medicare OPPS (APC and Fee Schedule) pricing. You have denied this claim in error, please review and remit the expected reimbursement."
Amount in Dispute: $518.16

Respondent's Position

"... Under Division Rule 133.307, a provider has one year from the date of service to seek medical dispute resolution. The date of service in this case is February 9, 2022. North Central Baptist Hospital did not seek medical fee dispute resolution until April 10, 2023, more than a year after the

date of service. Accordingly, North Central Baptist Hospital failed to timely seek medical fee dispute resolution and the Division lacks jurisdiction to consider the hospital's request… "

Response Submitted by: Tokia Marine America 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 or denied 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.
- 797 - SERVICE NOT PAID UNDER MEDICARE OPPS.
- 802 - CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
- 96 – NON-COVERED CHARGES.
- 97 - PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- N569 – Not covered when performed for the reported diagnosis.
- N702 - Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
- N600 - Adjusted based on the applicable fee schedule for the region in which the service was rendered.

Issues

1. Is North Central Baptist Medical Center entitled to reimbursement for the disputed services?

Findings

1. North Central Baptist Medical Center is seeking additional reimbursement for CPT code 27380 rendered on date of service February 9, 2022. The medical fee dispute request form DWC060 was received on April 10, 2023.

28 Texas Administrative Code (TAC) §133.307 (c) sets out the timely filing procedures for Medical Fee Dispute Resolution requests. It requires a request for MFDR that does not meet any exceptions listed in TAC §133.307(c)(1)(B) to be filed no later than one year after the dates of service in dispute.

The request was filed later than one year after the disputed date of service. Review of the submitted documents finds the disputed service does not involve any of the exceptions listed in TAC §133.307(c)(1)(B).

The division finds that North Central Baptist Medical Center is not entitled to 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 that $0.00 reimbursement is due.

Order

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

Authorized Signature:

		May 8, 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.tas.gov.