



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Complete Surgery Houston North

Respondent Name

Indemnity Insurance Co. of North America

MFDR Tracking Number

M4-24-0053-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

September 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
03/02/2021	62362	\$33,335.32	\$0.00
03/02/2021	62365	\$5,753.52	\$0.00
03/02/2021	62368	\$43.84	\$0.00
03/02/2021	77003	\$0.00	\$0.00
03/02/2021	C1772	\$0.00	\$0.00
03/02/2021	00670	\$0.00	\$0.00
Total		\$39,132.68	\$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: \$39,132.68

Respondent's Position

"Under Division Rule 133.307(c)(1)(A), a Request for Medical Fee Dispute Resolution must be provided within one year of the date of service. It does not appear that Complete Surgery Houston North's request for medical fee dispute resolution was made until September 5, 2023. Accordingly, the dates of service at issue is outside of the one-year deadline and the Division lacks jurisdiction to consider this dispute."

Response Submitted by: ESIS

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 \(TAC\) §133.307](#) sets out the procedures for Medical Fee Dispute Resolution requests.

Denial Reasons

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

- 1 - Previous gross recommended payment amount on line: \$0; Previous recommended payment amount on line: \$0, Additional recommended allowance of \$15489.46 is being made based upon additional supporting documentation received.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 11 - Additional recommendation is based upon additional supporting documentation received.
- 12 – A technical Bill Review (TBR) has been performed.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Has the requestor waived its right to medical fee dispute resolution (MFDR)?

Findings

1. The requestor is seeking reimbursement for professional medical services rendered on disputed date of service March 2, 2021. The medical fee dispute request form DWC060 was received by the division on September 5, 2023.

28 Texas Administrative Code (TAC) §133.307 (c)(1)(A) 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 services do not involve any of the exceptions listed in TAC§133.307(c)(1)(B). DWC finds that the requestor 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.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor, Complete Surgery Houston North, is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature:

September 20, 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 electrónico CompConnection@TDI.Texas.gov