



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Providence Memorial Hospital

Respondent Name

El Paso County Community College District

MFDR Tracking Number

M4-24-0238-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

October 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 15, 2022	250	Left Blank	\$0.00
June 15, 2022	278/C1713	Left Blank	\$0.00
June 15, 2022	278/C1765	Left Blank	\$0.00
June 15, 2022	300/C9803	Left Blank	\$0.00
June 11, 2022	300/80053	Left Blank	\$0.00
June 15, 2022	300/84132/XU	Left Blank	\$0.00
June 11, 2022	300/85025	Left Blank	\$0.00
June 11, 2022	300/87635	Left Blank	\$0.00
June 11, 2022	3620/71046	Left Blank	\$0.00
June 15, 2022	360/29807	Left Blank	\$0.00
June 15, 2022	360/29807/XU/RT	Left Blank	\$0.00
June 15, 2022	370	Left Blank	\$0.00
June 15, 2022	636/J0330	Left Blank	\$0.00
June 15, 2022	636/J0690	Left Blank	\$0.00
June 15, 2022	636/J1100	Left Blank	\$0.00
June 15, 2022	636/J2250	Left Blank	\$0.00
June 15, 2022	636/J2250	Left Blank	\$0.00
June 15, 2022	636/J2370	Left Blank	\$0.00
June 15, 2022	636/J2405	Left Blank	\$0.00
June 15, 2022	636/J2704	Left Blank	\$0.00

June 15, 2022	636/J2710	Left Blank	\$0.00
June 15, 2022	636/J2795	Left Blank	\$0.00
June 15, 2022	636/J7050	Left Blank	\$0.00
June 15, 2022	636/J7120	Left Blank	\$0.00
June 15, 2022	J7120	Left Blank	\$0.00
June 15, 2022	730	Left Blank	\$0.00
Total		Left Blank	\$0.00

Requestor's Position

The requestor did not submit a position statement with their request for MFDR. They did submit a copy of their reconsideration dated August 21, 2022 that states, "Your Plan denied reimbursement, but failed to provide any information supporting that the services and level of care billed were not medically necessary."

Amount in Dispute: \$95,601.00

Respondent's Position

The Austin carrier representative for El Paso Community College is Down Stanford. The representative was notified of this medical fee dispute on October 10, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response submitted by: N/A

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 resolving medical fee disputes.

Denial Reasons

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

- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor is seeking payment for outpatient hospital services rendered in June of 2022. The insurance carrier reduced the payment amount based on workers’ compensation fee schedule.

DWC Rule 28 TAC §133.307(c)(1) states:

"Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the division receives the request.

- (A) A request for medical fee dispute resolution 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.
- (B) A request may be filed later than one year after the date(s) of service if:
 - (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;
 - (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or
 - (iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The date of the service in dispute is June 11, 2022 and June 15, 2022. The request for medical dispute resolution was received at the Division on October 2, 2023.

Review of the submitted documentation found insufficient evidence to support an exception as detailed above. The requestor has waived their right to MFDR.

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 is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 15, 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 electrónico CompConnection@tdi.texas.gov.