

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

NORTHEAST BAPTIST  
HOSPITAL

**MFDR Tracking Number**

M4-24-0389-01

**Respondent Name**

ARCH INSURANCE CO

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

October 17, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 30, 2020	Hospital Outpatient	\$636.87	\$0.00
<b>Total</b>		\$636.87	\$0.00

### Requestor's Position

"Please allow this letter to serve as a formal reconsideration. The above reference claim was denied for untimely filing. Every effort is made at the time of service to obtain complete and accurate insurance information from your member in order to submit the claim in a timely manner and collect payment for the above reference services."

**Amount in Dispute:** \$636.87

### Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

**Response Submitted by:** Gallager Bassett

### 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 [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 90096 – The time limit for filing has expired
- 29 – The time limit for filing has expired
- 4271 – Per Tx Labor Code Sec 408.027 providers must submit bills to payors within 95 days of the date of service
- P12 – Workers Compensation Jurisdictional fee schedule adjustment
- 6340 – Charge for this procedure exceeds the OPPS schedule allowance
- 90223 – The time limit for filing has expired
- 5721 – To avoid duplicate bill denial for all reconsideration/adjustments/additional payment requests, submit a copy of this EOR or clear notati
- 90563 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600
- 5283- Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract or

## Issues

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

## Findings

1. 28 Texas Administrative Code §133.307(c)(1) 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.

The date of the services in dispute is July 30, 2020. The request for medical fee dispute resolution was received on October 17, 2023. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute; consequently, the requestor has waived the right to medical fee dispute resolution.

### 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 that no additional reimbursement is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**



January 5, 2024

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.texas.gov](mailto:CompConnection@tdi.texas.gov).