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
Sierra Medical Center

Respondent Name
El Paso County Hospital District

MFDR Tracking Number
M4-24-0430-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
October 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 3, 2022	23420-RT	$2,116.42	$0.00
	Total	$2,116.42	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "After reviewing the payment, we realized that there is an underpayment on the claim. According to our states fee schedule, implants should be paid at cost plus the lesser of 10% or $1,000 per item, not to exceed $2,000 per admission. Using this calculation, the reimbursement for the implants (CPT codes C1713 and C1762) should have been $2,000. Copies of medical records including the invoice for the implants are enclosed for your review."

Amount in Dispute: $2,116.42

Respondent's Position

"The bill in question was processed and payment, in the amount of $12,091.70, was issued on 7/8/2022. On 11/28/22 a reconsideration was received, but was sent back to the provider on 11/29/2022 advising a copy of the UB04 is required for reconsiderations. On 7/5/2023 a reconsideration was received which included a copy of the UB04, however no additional payment was issued as it was past timely filing for a reconsideration. It is our position payment issued was correct and no further reimbursement is due."

Response submitted by: Claims Administrative Services, Inc.

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:

- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.

Issues

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

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered in June of 2022. The insurance carrier reduced the disputed services based on packaging and 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 3, 2022. The request for medical dispute resolution was received at the Division on October 20, 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

		November 2, 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.texas.gov.