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
Texas Regional Medical Center

Respondent Name
City of Richardson

MFDR Tracking Number
M4-24-0597-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
November 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 16, 2023 [sic] to June 23, 2023 [sic]	97530	$92.56	$0.00
June 16, 2023 [sic] to June 23, 2023 [sic]	97140	$100.12	$0.00
June 16, 2023 [sic] to June 23, 2023 [sic]	97112	$45.24	$0.00
June 16, 2023 [sic] to June 23, 2023 [sic]	97110	$0.00	$0.00
	Total	$703.58[sic]	$0.00

Requestor's Position

"On September 1, 2008 the Texas Workers Compensation Fee Schedule and Guidelines for Hospitals drastically changed. The Fee Schedule generally allows for greater reimbursement and the **TWCC adopted Medicare/CMS Billing Guidelines and methodologies**."

Amount in Dispute: $703.58

Respondent's Position

"The dates of service in dispute are in June 2022. The Request for Medical Fee Dispute

Resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 10, 2023. This date of receipt is more than one year after the date of service in dispute. The disputes service does not involve issues identified in Section 133.307(c)(1)(B). Therefore, Carrier submits that Requestor has failed to timely file this dispute with the Division's MFDR Section and has consequently waived the right to medical fee dispute resolution."

Response submitted by: White Espey PLLC

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.
- P15 – Workers' Compensation Medical Treatment Guideline Adjustment.
- T13 – Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 11 months from the date of service.
- T113 – level 1 appeal means a request for reconsideration under 133.250
- W3 – Additional payment made on appeal/reconsideration (TXWC)

Issues

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

Findings

1. The requestor is seeking payment for outpatient physical therapy services rendered in June 2022. The insurance carrier originally denied the claim based on medical necessity. This denial was not maintained and a payment in the amount of $2106.46 was made.

   The DWC060 submitted with the request for MFDR indicates dates of service June 1, 2023 to June 23, 2023. This information is not supported by the medical bill and explanation of benefits that indicates dates of service adjudicated to be June 1, 2022 to June 23, 2022.

These dates of service will be reviewed by applicable DWC rules.

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 1, 2022 to June 23, 2022. The request for medical dispute resolution was received at the Division on November 10, 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

		December 6, 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.