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
BAPTIST MEDICAL CENTER

Respondent Name
ACIG INSURANCE CO

MFDR Tracking Number
M4-24-0881-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
December 19, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 28, 2022	Hospital Inpatient Revenue Code 563	$1,590.57	$0.00
	Total	$1,590.57	$0.00

Requestor's Position

"We have received payment in the amount of $8,598.15 with $00.00 as patient responsibility. We are requesting an additional $1,590.57. After reviewing the payment, we realized that there is an underpayment on the claim. According to our Workers Compensation contract, we are entitled to receive $10,188.72."

Amount in Dispute: $1,590.57

Respondent's Position

"ACIG would first show that the Division lacks jurisdiction to review this Dispute. Per DWC Rule 133.307(c)(1), a requestor must timely file a request for medical fee dispute resolution, or waive the right to a MFDR Decision. Rule 133.307 (c)(1)(A) mandates that a request for medical fee dispute resolution must be filed no later than one year after the date of service in dispute. As the date of service at issue herein in April 28, 2022, Requestor's DWC-60 was due by April 28, 2023; however, it was not filed until December 19, 2023. As such, Requestor has waived the right to Medical Fee Dispute Resolution."

Response Submitted by: Burns Anderson Jury & Brenner LLP

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:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- P15 – Workers' compensation medical treatment guideline adjustment
- W3 – Additional payment made on appeal/reconsideration. Level 1 appeal means a request for reconsideration under 133.250 Your billing has been in accordance with this Inpatient Hospital fee schedule
- @F – Additional payment made on appeal/reconsideration
- T113 - Level 1 appeal means a request for reconsideration under 133.250
- ZE – Your billing has been paid in accordance with the Inpatient Hospital Fee Schedule
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

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

Findings

1. 28 Texas Administrative Code §133.307(c)(1)(A) 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 April 28, 2022. The request for medical fee dispute resolution was received on December 19, 2023. This date is later than one year after the date(s) of service in dispute. A 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 entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 26, 2024 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.