



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Momentum Specialty
Surgery Center

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-23-2910-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

July 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 26, 2022	29828 RT	\$6,319.43	\$0.00
August 26, 2022	29828 RT	\$3,159.72	\$0.00
August 26, 2022	29826 RT	\$0.00	\$0.00
August 26, 2022	20900	\$3,159.72	\$0.00
Total		\$12,638.86	\$0.00

Requestor's Position

"...2/22/2023 I spoke with Dara ref# MT008637 claim denied not marked reconsideration/ corrected claim on HCFA I was told last time to put on letter stating what changes was I was not happy with lady told her I have done everything they have asked, and they keep making excuses to not pay I have refax 33 page with reconsideration/corrected claim on HFCA... I have included all our correspondence. The claim is correct, and it is not clear what they are looking for to get paid."

Amount in Dispute: \$12,638.86

Respondents' Position

The Austin carrier representative for Ace American Insurance Co is Downs Stanford PC. The representative was notified of this medical fee dispute on July 25, 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.

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 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §133.10](#) sets out the claim form requirements of medical bills.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- Bill is denied; invalid / missing healthcare provider license number.
- 18 – Duplicate claim/service.
- 148 – This procedure on this date was previously reviewed.

Issues

1. Did the requestor support their position statement?

Findings

1. The requestor states in their position statement, "The claim is correct." Review of the medical bill dated February 7, 2023, indicates the NPI number 1871169136 in box 33 (b).

DWC Rule 28 TAC 133.10(f)(1) (EE) states, "billing provider's state license number (CMS-1500/field 33b) is required when the billing provider has a state license number; the billing provider must enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'). Review of the Texas ASC license directory at <https://vo.ras.dshs.state.tx> found a listing for Momentum Specialty Surgery Center located in Wichita Falls, TX. As Momentum Specialty

Surgery Center is listed in box 33 as the billing provider their associated license number was required in box 33(b) of their medical bill.

The DWC finds insufficient evidence to support the requestor corrected the claim to meet the criteria of the rule shown above. No payment is recommended.

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 requestor has not established that 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

_____	_____	December 13, 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. 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.