



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PROVIDENCE MEMORIAL HOSPITAL

Respondent Name

OLD REPUBLIC INSURANCE CO

MFDR Tracking Number

M4-24-1300-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

February 14, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 12, 2022	Hospital Outpatient	\$6,478.15	\$0.00
Total		\$6,478.15	\$0.00

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Sedgwick, but the bill was underpaid. However, despite the Hospital's efforts and Request for Reconsideration Sedgwick has not rendered proper payment."

Amount in Dispute: \$6,478.15

Respondent's Position

The Respondent did not respond to the Medical Fee Dispute Resolution request.

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:

- 247 – A payment or denial has already been recommended for this service
- 18 – Exact duplicate claim/service
- N111 – No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated
- 4915 – The charge for the services represented by the code is included/unbundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the services is packaged or excluded from payment
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 877 -Reimbursement is based on the contracted amount
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- N702 – Decision is based on review of previously adjudicated claims or for claims in process for the same/similar type of services
- N600 – Adjusted based on the applicable fee schedule for the region in which the services were rendered.
- QA – Other adjusted.
- 1014 – The attached billing has been re-evaluated at the requestor of the provider.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 5094 – DWC requires a request for reconsideration or corrected claims to be submitted when 10 months of the date of service.
- 193 – original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 29 – The time limit for filing has expired.
- W3 – Bill is a reconsideration or appeal.
- 2 – Devise payment was based on documentation provided by your facility.
- 57 – Payment denied/reduced because the payer deems the information submitted does not support this type of service, this many services, this length of service, this dosage, or this day's supply.

Issues

1. Did the insurance carrier respond to the request for dispute resolution?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The Austin carrier representative for Old Republic Insurance Co is White Espey PLLC. White Espey PLLC was notified of this medical fee dispute on February 21, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).
2. 28 TAC §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 January 12, 2022. The request for medical fee dispute resolution was received on February 14, 2024. This date is later than one year after the date(s) of service in dispute. 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

Sandra Hernandez
 Medical Fee Dispute Resolution Officer

April 22, 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 electrónico CompConnection@tdi.texas.gov.