



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

RESOLUTE HEALTH
SYSTEM

Respondent Name

TECHNOLOGY INSURANCE COMPANY I

MFDR Tracking Number

M4-24-1471-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

March 7, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 15, 2022	Hospital Outpatient	\$3,823.31	\$0.00
Total		\$3,823.31	\$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 Amtrust, but the bill was underpaid. However, despite the Hospital's efforts and Request for Reconsideration, Amtrust has not rendered payment."

Amount in Dispute: \$3,823.31

Respondent's Position

"Medical Fee Dispute Resolution received Requestor's DWC-60 on 3/07/2024 as evidenced by the date stamp on the DWC-60. The date of service in dispute is 9/15/2022, and the EOBs did not reflect any extent, liability or medical necessity issues. Therefore, Respondent requests Medical Fee Dispute Resolution enter a Findings and Decision stating Requestor waived their right to dispute resolution as the request was not filed within one year of the date of service."

Response Submitted by: Downs Stanford PC

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:

- 252 – An attachment/other documentation is required to adjudicate this claim/service
- 253 – In order to review this charge please submit a copy of the certified invoice
- 350 – Bill has been identified as a request for reconsideration or appeal
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
- 618 – the value of this procedure is packaged into the payment of other services performed on the same date of service
- M127 – Missing patient medical record for this service
- MA27 – Missing/incomplete/invalid entitlement number or name known on the claim
- MA30 – Missing/incomplete invalid type of bill
- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

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

Findings

1. 28 Texas Administrative Code §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 September 15, 202. The request for medical fee dispute resolution was received on March 7, 2024. This date is later than one year after the date(s) of service in dispute. 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

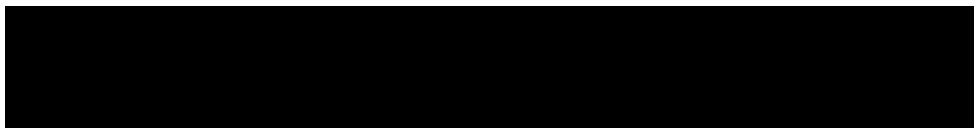
The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

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



April 4, 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 electronico CompConnection@tdi.texas.gov.

