



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Providence Sierra

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-25-0385-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

October 18, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 23, 2023 – June 12, 2023	0111	\$95,660.00	\$0.00
	0250	\$5,688.43	\$0.00
	0258	\$655.00	\$0.00
	0278	\$2248.00	\$0.00
	0300	\$102,129.00	\$0.00
	0310	\$7,361.00	\$0.00
	0320	\$1,467.00	\$0.00
	0360	\$146,938.00	\$0.00
	0370	\$22,648.00	\$0.00
	0402	\$2,528.00	\$0.00
	0424	\$1,889.00	\$0.00
	0430	\$1,931.00	\$0.00
	0434	\$2,364.00	\$0.00
	0610	\$4,677.00	\$0.00
	0636	\$96,736.00	\$0.00
	0710	\$15,788.00	\$0.00
	0761	\$1,944.00	\$0.00
	WC ADJUSTMENTS	-\$465,760.54	\$0.00
	Total	\$46,890.89	\$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 GALLAGHER, but the bill was denied."

Amount in Dispute: \$46,890.89

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Supplemental response submitted November 6, 2024

"Our bill audit company has determined no further payment is due."

Response submitted by Gallagher Bassett

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:

- 31065 – This service was not pre-authorized in conformance with TWCC Rule 134.600.
- 65003/FQ03 – Per your Coventry Integrated Contract.

Issues

1. Did the insurance carrier support a contract between the two parties?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The insurance carrier included a denial code that indicates a "Coventry Contract." Review of the submitted documentation and information known to the Division does not support the

injured worker is enrolled in a certified health network. This reduction code will not be considered during this review.

2. The requestor is seeking payment for inpatient hospital services rendered from May 23, 2023 until June 12, 2023. The insurance carrier denied the claim for lack of prior authorization. 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 dates of the service in dispute are May 23, 2023 through June 12, 2023. The request for medical dispute resolution was received at the Division on October 18, 2024.

Review of the submitted documentation found insufficient evidence to support an exception as detailed above. The requestor has waived their right to MFDR for the disputed dates of service.

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 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

November 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.