



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Resolute Health System

Respondent Name

Comal ISD

MFDR Tracking Number

M4-25-0426-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

October 14, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 27, 2023 to March 3, 2023	0250	\$327.00	\$0.00
	0272	\$440.04	\$0.00
	0278	\$32046.00	\$0.00
	0300	\$3101.00	\$0.00
	0360	\$43590.10	\$0.00
	0370	\$10965.00	\$0.00
	0636	\$2453.00	\$0.00
	0710	\$2708.00	\$0.00
	WC ADJUSTMENT	-83981.42	\$0.00
	Total	\$11,648.72	\$0.00

Requestor's Position

"The Hospital requested CAS review underpayment and issue payment. However, despite the Hospital's efforts and Request for Reconsiderations sent on June 20, 2024 and on October 31, 2023 CAS has not issued proper payment."

Amount in Dispute: \$11,648.72

Respondent's Position

“The provider did not document separate implant reimbursement on the UB04 for either the initial billing or the reconsideration. At this time, the services are well in excess of 12 months from DOS. It is our position that the bill in question was paid correctly, and no additional reimbursement would be due.”

Response submitted by: CAS – Claims Administrative Services, Inc.

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:

- 722 – The extent of injury has been disputed. This treatment is unrelated to the compensable workers’ compensation injury.
- 219 – Based on extent of injury.
- 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.
- 305 – The implant is included in this billing and reimbursed at the higher percentage calculation.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Has the requestor waived the right to medical fee dispute resolution?

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered in February 27, 2023 to March 3, 2023. The denial for compensability/extent was not maintained. The Insurance carrier made a payment of \$12,029.90 on June 16, 2023.

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 February 23, 2023 through March 3, 2023. The request for medical dispute resolution was received at the Division on October 14, 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 dates of service February 27, 2023 through March 3, 2023.

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

Signature

Medical Fee Dispute Resolution Officer

January 14, 2025

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.