TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Transmountain

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-25-0528-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 28, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 6 – 20, 2023	0250	$741.00	$0.00
	0278	$54005.59	$0.00
	0300	$2701.00	$0.00
	0360	$58340.00	$0.00
	0370	$11361.00	$0.00
	0636	$4217.00	$0.00
	0710	$7370.00	$0.00
	WC ADJUSTMENTS	-124809.95	$0.00
	Total	$13,961.64	$0.00

Requestor's Position

"…Under Texas Labor Code §408.0272 a health care provider does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if the claim was erroneously filed for reimbursement with a workers' compensation carrier other than the carrier liable for payments of benefits. In this case, Claims Admin Services insurance information was provided to the Hospital and billed. As such, Broadspire is responsible for the proper payment of the medically necessary treatment directly related to the patient's work-related injury."

Supplemental response submitted February 24, 2025

"…A balance of $3,265.98 remains."

Amount in Dispute: $13,961.64

Respondent's Position

"We are in receipt of the above captioned medical fee dispute resolution Payment has been made for $10,695.66. We have attached the EOB."

Response submitted by: Broadspire

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

- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 885 – Review of this code has resulted in an adjusted reimbursement.
- A19 – Upon further review, additional payment is warranted.
- P11 – Allowance was reduced as per contractual agreement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- 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. The requestor is seeking payment for outpatient hospital services rendered in April of 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 April 6 – 20, 2023. The request for medical dispute resolution was received at the Division on October 28, 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 in dispute.

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 requester 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.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 27, 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 electronico CompConnection@tdi.texas.gov.