



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Scott and White Clinic

Respondent Name

Accident Fund General Insurance Company

MFDR Tracking Number

M4-25-1049-01

Carrier's Austin Representative

Box Number 06

Date Received

January 16, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 20, 2023	25111	\$2,754.91	\$0.00

Requestor's Position

"...BSWH requested authorization for the outpatient services, submitted clinical documentation and the outpatient services were approved. United Heartland failed to process this claim for payment to BSWH."

Amount in Dispute: \$2,754.91

Respondents' Position

"Seven months later the claimant presented with a diagnosis of... by Dr Austin Hoy, MD dated 10/05/2023 who indicated that the Claimant had presented with this condition for over a year or on or about 10/05/2022 which predates the date of injury.... The Carrier received the request for surgery 10/11/2023 and a peer review was requested to address the requested medical procedure 10/11/2023... the... did not arise out of the course and scope of her employment and the bill remains denied"

Response Submitted by: United Heartland

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](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- P12 – The services have been paid at fifty (50%) percent of the anesthesia allowance. An anesthesiologist has medically directed the services of a CRNA or anesthesia assistant.
- 5088 – Provider not authorized.
- 5089 – Services not authorized.
- 5098 – This billing is for a service unrelated to the work injury/illness.
- 5180 – Bill denied as the injury is not work related.
- 5347 – Services are unreasonable and unnecessary.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Note: Coventry Health Care (TX HCN) the payment was reviewed using an existing PPO contracted arrangement.
- @G W3 – No additional reimbursement allowed after review of appeal/reconsideration.
- PN 97 – The service is considered incidental packaged or bundled into another service or APC payment.
- PS P12 – The charge exceeds the APC rate for this service.
- XD P12 – This bill was submitted after the billing timeliness guidelines provided.

Issues

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

Findings

- 1. The requestor seeks payment in the amount of \$2,754.91 for medical services provided on October 20, 2023.

The service in question was performed on October 20, 2023. The medical fee dispute was received by the Division on January 16, 2025.

Per 28 TAC §133.307 (c)(1), the requestor must request medical fee dispute resolution within one year from the date of service, unless a related compensability, extent of injury, or liability dispute exists; or a dispute regarding medical necessity has been filed. If these exceptions apply, a request for medical fee dispute resolution must be filed within 60 days after the date the requestor receives the final decision.

The DWC received the medical fee dispute resolution request on January 16, 2025. This is more than one year after the date of service October 20, 2023. DWC found no evidence to support that an exception applied to this date of service.

A review of the submitted documentation finds that the disputed service does not involve issues identified in 28 TAC §133.307 (c) (1) (B). The DWC concludes that the requestor has failed to timely file this dispute with the Division; 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.

The Division finds the requestor has not established that reimbursement is due.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 3, 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. The Division must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to the Division using the contact information on the form or the field office handling the claim. If you have questions about the DWC Form-045M, 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 the Division. **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.