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
Legent Interventional Pain

Respondent Name
City of Arlington

MFDR Tracking Number
M4-25-1069-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 22, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 22, 2024	CPT 63685, 63663, C1778, C1822	$5,445.42	$0.00

Requestor's Position

"We have been underpaid per the TX WC FS- below are calculations and we have submitted a previous appeal which was upheld for the original payment. We are Expecting $5,445.42 in an additional payment."

Amount in Dispute: $5,445.42

Respondent's Position

"Based on a review of the claim history and the submitted documentation. Additional payment is not recommended. Our records indicate prior processing is within guidelines."

Response Submitted by: Injury Management Organization, Inc.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.2 provides definitions for medical billing and processing rules.
2. 28 TAC §133.10 sets out the procedures for required billing forms/formats.
3. 28 TAC §133.200 sets out the procedure for medical bill processing/audit by insurance carrier.
4. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Adjustment Reasons

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

- 222 - Charge exceeds Fee Schedule allowance
- 119 - Benefit maximum for this time period or occurrence has been reached.
- 16 – Claim/service lacks information or has submission/billing error(s).
- 881 - This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
- 193 - Original payment decision Is being maintained. Upon review, it was determined that this claim was processed properly.
- 97 - The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
- W3 - TDI Level 1 appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.
- Notes: Reconsideration of EOB… The appropriate reimbursement was allowed no additional reimbursement is considered.

Issues

1. Did the requestor submit its request for medical fee dispute resolution (MFDR) in accordance with DWC Rule 28 TAC §133.307?

2. Did the requestor submit a complete medical bill for the services in dispute?

3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. DWC received this MDFR request on January 22, 2025, for services rendered on January 22, 2024. DWC Rule 28 TAC §133.307, which sets out the procedures for resolution of medical fee disputes, states in pertinent part, "(c) Requests. Requests for MFDR must be legible and filed in the form and manner prescribed by the division… (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include: … (M) a copy of all applicable medical records related to the dates of service in dispute."

   A review of all documentation available at the time of this review finds that no medical records related to the disputed date of service were submitted.

   DWC finds that the requestor did not submit its request for medical fee dispute resolution (MFDR) in accordance with DWC Rule 28 TAC §133.307.

2. DWC Rules require that health care providers submit complete medical bills for reimbursement of medical services.

   28 TAC §133.2(4) defines a "complete medical bill" as "A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter …, or as specified for electronic medical bills in §133.500 of this chapter…"

   28 TAC §133.10(f)(1) (AA) states, "service facility location information (CMS-1500/field 32) is required."

   A review of the medical bills submitted finds that field 32 of the CMS-1500 medical bill form submitted is blank with no facility location information present on the CMS-1500 medical billing form as required by 28 TAC §133.10(f)(1) (AA). The place of service information is required for DWC to determine the appropriate medical fee reimbursement and whether the insurance carrier paid for the disputed services according to the fee guideline.

   DWC finds that the requestor did not submit a complete medical bill, in accordance with 28 TAC §133.10, for the services in dispute.

3. The requestor is seeking additional reimbursement in the amount of $5,445.42 for services rendered on January 22, 2024.

   In its review of the submitted documentation, DWC found no evidence to support that the requestor submitted a complete medical bill to the insurance carrier in accordance with 28

TAC §133.10(f), for the services in dispute.

In its review of the submitted documents, DWC found no medical records related to the disputed services were submitted with this request for MFDR in accordance with 28 TAC §133.307.

For these reasons, DWC finds that the requestor is not entitled to additional reimbursement for the services rendered on January 22, 2024.

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 additional reimbursement is due.

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	March 31, 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, call CompConnection at 1-800-252-7031, option three, 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 tres o correo electronico CompConnection@tdi.texas.gov.