

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

DOCTORS HOSPITAL AT RENAISSANCE

**Respondent Name**

EMPLOYERS INSURANCE CO OF WAUSAU

**MFDR Tracking Number**

M4-25-1162-01

**Carrier's Austin Representative**

Box Number 60

**Date Received**

January 29, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 2, 2024 to January 4, 2024	Hospital Outpatient	\$446.78	\$0.00

### Requestor's Position

"After reviewing the account we have concluded that reimbursement received was inaccurate. Based on Code 97110 allowed amount of \$31.47 x 3 multiplied at 200%, CPT Code 97112, allowed amount of \$35.85 x 2, multiplied at 200% and CPT Code 97140, allowed amount of \$28.64 x 2, multiple at 200% reimbursement should be \$446.78. Payment received was only \$0.00 thus, according to these calculations; there is payment in the amount of \$446.78."

**Amount in Dispute:** \$446.78

### Respondent's Position

"This bill for DOS 1/2/2024 and 1/4/2024 will not be reviewed as this dispute has been submitted pas the timely filing deadline per Rule 133.307: A request for MFDR 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. The MFDR was filed on 1/29/25 which is greater than time allotted."

## **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 denied the payment for the disputed services with the following claim adjustment codes:

- 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600
- 197 – no denial reason given
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

### **Issues**

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

### **Findings**

The requestor seeks payment in the amount of \$446.78, for medical services provided on January 2, 2024 to January 4, 2024.

28 TAC §133.307 (c) (1) states in the pertinent part, "Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section."

The service in question was performed on January 2, 2024 to January 4, 2024. The medical fee dispute was received by the Division on January 29, 2025. This date is more than a year following the in-question date(s) of service.

28 TAC §133.307 (c) (1) (A) states, "A request for MFDR 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."

A review of the submitted documentation finds that the disputed service(s) does not involve issues identified in 28 TAC §133.307 (c) (1) (B). The Division 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**

	<u>February 21, 2025</u>
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).