



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Health Hospital Mansfield

Respondent Name

Insurance Company of the West

MFDR Tracking Number

M4-25-1186-01

Carrier's Austin Representative

Box Number 04

DWC Date Received

January 31, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 25, 2024 – January 26, 2024	Hospital Outpatient Services	\$4,594.51	\$0.00

Requestor's Position

"23410 was paid below the expected reimbursement. Per TX State Fee Schedule, surgical code should be reimbursed at 200% GARR which the expected reimbursement is \$13,127.16. Previous payment received totaled \$8,532.65. Please review and pay the remaining balance due of \$4,594.51 per the TX fee schedule calculations below.

"UB TX O/P: Surgical @200% GARR=\$13,127.16"

Amount in Dispute: \$4,594.51

Respondent's Position

The Austin carrier representative for Insurance Company of the West is the Law Office of Ricky D Green. The representative was notified of this medical fee dispute on February 4, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Missing patient medical record for this service.
- Missing/incomplete/invalid entitlement number or name shown on the claim.
- Missing/incomplete/invalid type of bill.
- Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 397 – Allowance is based on utilization review pre-authorization.
- 668 – The allowance for this line item is based on an outlier reimbursement.
- All submitted documentation regarding the attached claim has been re-evaluated. It is our opinion that the review is accurate; therefore, no additional allowance is recommended.

Issues

1. Did Texas Health Hospital Mansfield forfeit the right to medical fee dispute resolution for the date of service in question?

Findings

1. Texas Health Hospital Mansfield is seeking additional reimbursement for outpatient hospital services provided January 25, 2024, to January 26, 2024.

Per 28 TAC §133.307 (c)(1), the health care provider 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 31, 2025. This is more than one year after date of service ending January 26, 2024. DWC found no evidence to support that final adjudication of an exception applied to this date of service.

DWC finds that Texas Health Hospital Mansfield has waived the right to medical fee dispute resolution for this date of service.

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 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 30, 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 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 electrónico CompConnection@tdi.texas.gov.