



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

North Central Baptist
Medical Center

Respondent Name

Texas Municipal League Intergovernmental

MFDR Tracking Number

M4-25-1858-01

Carrier's Austin Representative

Box Number 19

Date Received

April 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 14, 2024 – February 19, 2024	Hospital Services	\$21,672.19	\$0.00

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed TML, but the bill was underpaid and not paid/reimbursed appropriately. However, despite the Hospital's efforts and Request for Reconsiderations sent to TML June 6, 2024, and March 31, 2025, TML has not rendered proper payment."

Amount in Dispute: \$21,672.19

Respondent's Position

"The additional request by the provider appears to be for implants. However, the provider did not request nor indicate in its initial medical bill that implants were to be paid separately. Accordingly, reimbursement for implants was included with the recommended amount from the carrier's initial EOB. When the provider filed the request for reconsideration to include a separate payment for implants, the provider failed to include the invoices that the provider paid. Absent those invoices, the carrier is not required to reimburse any additional amounts."

Response Submitted by: Flahive, Ogden & Latson

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 – Workers' compensation jurisdictional fee schedule adjustment.
- 468 – Pricing is based on the medical hospital inpatient prospective payment system methodology.
- N45 – Payment based on authorized amou...
- 305 - The implant is included in this billing and is reimbursed at the higher percentage calculation.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
- U03 – The Billed service was reviewed by UR and authorized.
- N13 – Consult plan benefit documents/g
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 468 – Pricing is based on the medical hospital inpatient prospective payment system methodology.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Note: The original audit stands. No additional payment is due as no invoices for implants not direction included with billing.
- Note: The time limit for filing a request for reconsideration and/MDR has expired. Please reference DWC RULE I 33.307(d)
- NOTE-Original Bill was audited correctly as provider did not request separate reimbursement for implants. 1st Reconsideration was audited correctly-provider requested separate reimbursement for implants but failed to submit implant invoices. 2nd Reconsideration was submitted 412 days from date of service which exceeds the timely filing time frame. No additional amount is owed to the provider.

Issues

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

Findings

1. The requestor seeks payment in the amount of \$21,672.19, for medical services provided on several dates from February 14, 2024 through February 19, 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 February 14, 2024, through February 19, 2024. The medical fee dispute was received by the Division on April 14, 2025. This date is more than a year following the in-question dates 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 services 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

Signature

Medical Fee Dispute Resolution Officer

Date

May 8, 2025

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.