TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Memorial Hospital

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-25-1990-01

Carrier's Austin Representative
Box Number 60

Date Received
April 25, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 28, 2022	Hospital Services	$26,527.50	$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 MITCHELL, but the bill was not paid/reimbursed appropriately."

Amount in Dispute: $26,527.50

Respondent's Position

"We are standing on the previous denial as the claim was denied as Extent of Injury therefore the bill was issued to the incorrect venue."

Response Submitted by: Mitchell on behalf of Service Lloyds Insurance Co

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 the payment for the disputed services with the following claim adjustment codes:

- 18 - Exact duplicate claim/service.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 219 - Based on extent of injury.
- 224 - Duplicate charge.
- 351 - No additional reimbursement allowed after review of appeal/reconsideration.
- 375 - Please see special *note* below.
- 751 - Extent of injury not finally adjudicated
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- Note: MFDR -M4-25-1990-01 Stand on previous denial as this claim is denied for extent of injury.

Issues

1. Is the Insurance Carrier's denial of extent of injury supported?

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

Findings

1. The requestor seeks reimbursement for $26,527.50 rendered on October 28, 2022. The medical services in dispute were denied by the workers' compensation carrier due to an unresolved extent of injury issue.

   28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   A review of the submitted documentation finds that the respondent did not provide documentation to the DWC to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H). The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise

been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC.

Because the service in dispute does not contain an unresolved extent of injury issue, this matter is eligible for adjudication pursuant to the applicable rules and guidelines.

2. The requestor seeks payment in the amount of $26,527.50, for medical services provided on October 28, 2022.

   The service in question was performed on October 28, 2022. The medical fee dispute was received by the Division on April 25, 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 April 25, 2025. This is more than one year after the date of service October 28, 2022. 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(s) do/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 requester has not established that reimbursement of 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

		May 8, 2025
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. 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 electronico CompConnection@tdi.texas.gov.