



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HOUSTON HOSPITAL FOR SPECIALIZED SURGERY

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-1109-01

Carrier's Austin Representative

Box Number: 54

MFDR Date Received

DECEMBER 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Houston Hospital for Specialized Surgery submitted first claim on 02/04/13 to Dallas Batterson 955 Judiway Houston, TX 77018 as this was who we were informed to bill and [REDACTED] has signed a Letter of Guarantee (attached) that they would pay. We again billed [REDACTED] on 09/17/2013 after no response from our initial billing. On 09/24/2013 we received a call from Glen at Texas Mutual stating that the claims had gone to the employer and need to be resent to Texas Mutual. After we were informed of this we faxed the claim to Texas Mutual on that same day 09/24/2013 (attached are fax confirmation sheets). Our claim denied on 10/29/2013 and on 12/04/13 for timely filing."

Amount in Dispute: \$17,084.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual did not and does not find the rationale given by the requestor for the late bill persuasive."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2013	Hospital Outpatient Services	\$17,084.85	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
- 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
- Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
- Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

- 29 – The time limit for filing has expired.
- 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service. For services on or after 9/1/05.
- 193 – Original payment decision is being maintained. Upon review, it was discovered that this claim was process properly.
- 724 – No additional payment after a reconsideration of services.

Issues

1. Did the requestor bill the employer and did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(j) states, “The health care provider may elect to bill the injured employee’s employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following: (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (A) prompt payment, as provided by Labor Code §408.027; (B) interest for delayed payment as provided by Labor Code §413.019; and (C) medical dispute resolution as provided by Labor Code §413.031.” For that reason, the requestor in this dispute has waived the right to medical dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 17, 2014

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall 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*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.