



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

TEXAS HEALTH CLEBURNE

Respondent Name

AMERISURE MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-2515-01

Carrier's Austin Representative Box

Box Number 47

MFDR Date Received

APRIL 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by TX HEALTH CLEBURNE to audit their claims. A review this claim was denied for timely filing. Katy at [REDACTED] told us on 7/8/13 that they were paying this in-house and to send the bill to them. This was billed to them on 7/9/13. On 9/18/13, Katy said to send this to Amerisure. We bill Amerisure on 9/19/13. I have attached the hospital system notes for verification."

Amount in Dispute: \$2,899.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon further review of the original bill received on 10/24/2013, the provider included a computer printout of their billing history, which shows that the provider billed the employer, Westhill Construction, Inc., on 7/17/13..."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 5, 2001 through March 22, 2012	Professional Services	\$2,899.00	\$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by the health care provider.

Issues

1. Did the requestor bill the injured workers employer?
2. Has the requestor waived the right to Medical Fee Dispute Resolution?

Findings

1. According to the requestor's position summary, they initially billed the injured workers employer. According to 28 Texas Labor Code § 133.20(j), 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: (C) medical dispute resolution as provided by Labor Code §413.031.
2. The requestor has waived the right to Medical Fee Dispute Resolution.

Conclusion

For the reasons stated above, the Division finds that the reimbursement is not recommended. 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

		November 21, 2014
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 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.