



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

SETON MEDICAL CENTER

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-1668-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 03, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please be advised that our office represents SMCA (Seton Medical Center Austin), in connection with the above referenced matter. Please direct any correspondence or communication regarding this account through our office.

This letter is supplemental to Part V of the attached from DWC-60, and will serve as SMCA (Seton Medical Center Austin)'s "Requestor's Rationale for Increased Reimbursement or Refund." This dispute originated with TEXAS MUTUAL'S (hereinafter Carrier) denial of the above referenced claim based upon the assertion that the Claimant's presenting concerns did not constitute an emergency. Regarding this matter SMCA (Seton Medical Center Austin) (hereinafter Requestor) would show the following: ...

2. The charges incurred in the course of the Claimant's treatment totaled \$1,845.25

These charges were billed to and subsequently denied by the Carrier. It was the Carrier's contention that the "FILE DOCUMENTATION DOES NOT SUPPORT EMERGENCY SERVICES."

Amount in Dispute: \$302.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 7/30/2013

1. Review of the documentation from SETON NORTHWEST HOSPITAL does not show the treatment was a medical emergency.
2. Texas Mutual claim 99H00000510793 and SETON NORTHWEST HOSPITAL are participants in the Texas Star Network."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2013	CPT Code J1885, J1170, 0259, 99283-25 and 96372	\$302.16	\$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. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
 - 899 – Documentation and file review does not support an emergency in accordance with rule 133.2
 - CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly
 - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
 - 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) 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." The date of the services in dispute is July 30, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on February 03, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/19/15 Date
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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.