TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PINE CREEK MEDICAL CENTER

Respondent Name
EMPLOYERS ASSURANCE COMPANY

MFDR Tracking Number
M4-16-2133-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
March 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center was provided with BCBS as the patient primary insurance prior to services being rendered. . . . Pine Creek Medical Center billed BCBS . . . and payment was issued to our facility . . . leaving a patient balance . . . it wasn't until then patient informed Pine Creek Medical Center that this is and actual Workers' Compensation claim . . . claim was billed to Employer Insurance a denial EOB . . . was received indicating 'no authorization.' . . . An appeal was submitted . . . advising that authorization was obtained from BCBS and requesting that this claim be reimbursed. . . . I spoke with the adjuster . . . and she . . . stated that claim was still going to deny as authorization was not obtained from their pre-auth department."

Amount in Dispute: $8,342.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical treatment at issue in this case was non-emergency health care requiring pre-authorization. Rule 134.600(p). Despite that, the provider did not seek pre-authorization from the carrier prior to providing the services in question. Instead, the requestor provided the care under the claimant's group health insurance. In fact, the requestor submitted request for reimbursement from the group health carrier and accepted payment form the group health carrier. . . . according to BCBS, the requestor 'was advised that authorization or a referral was not required for the member's treatment plan.' In other words, the treatment at issue apparently required no pre-authorization from the group health insurer. . . . The fact that it inquired of a group health insurer whether pre-authorization was required and, apparently, was told no, is not sufficient to satisfy the pre-authorization requirement under the Workers' Compensation Act."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2014	Procedure Code 29862	$8,342.72	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 167 – this (these) diagnosis(es) is (are) not covered. (XA89)
   - 197 – Pre-certification or authorization or notification absent. (XB07)
   - 3 – Recommendation of payment has been based on this procedure code, 320, which best describes services rendered. (Z652)
   - 43 – Recommendation of payment has been based on this procedure code, 360, which best describes services rendered. (Z652)
   - * – Date(s) of service exceed (95) day time period for submission per RULE 408.027 and Bulletin No. B-0037-5A. (F286)

Issues

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 June 30, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 25, 2016. 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

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

ORDER

Based on 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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	June 3, 2016
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 MFDR 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.