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
ACADIAN AMBULANCE SERVICE OF TEXAS

Respondent Name
TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

MFDR Tracking Number
M4-18-1498-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
January 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This hospital to hospital transport was initially billed to the patients health insurance, . . . which paid. The patient was billed. Workers Compensation Insurance information was given to Acadian Ambulance in August by the patient. This information was not given at the time of transport by the patient nor the hospital which made it impossible to bill the proper carrier. . . . the time the patient gave the correct information to the time Acadian Ambulance billed the Workers' Compensation Insurance Carrier was five days. The patient's health insurance was filed within the initial 95 days. According to the Texas Guidelines, a provider has 95 days after receiving correct billing information to file a bill for proper payment. This guideline was followed by Acadian Ambulance but Travelers is denying the bill."

Amount in Dispute: $806.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider has waived the right to reimbursement under Rule 133.307 as they did not file their Request for Medical Fee Dispute Resolution with the Division within one year of the date of service . . . "

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 3, 2017	Ambulance Transportation Services	$806.08	$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:
   - 18 – DUPLICATE CLAIM/SERVICE
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 306 – BILLING IS A DUPLICATE OF OTHER SERVICES PERFORMED ON SAME DAY
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE
   - 4271 - PER TX LABOR CODE SEC 413.016, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED

Issues

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

Findings

1. 28 Texas Administrative Code §133.307(c)(1) requires that:

   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 January 3, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on January 23, 2018. 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 information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 9, 2018
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 Rule §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. **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.