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
B&W Healthcare Associates

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-2454-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our claims for the above dates of service were originally billed to the Employer, Ranger Freddy's Garage/DSC Environmental, on 09/05/2017."

Amount in Dispute: $702.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 7/31/2018 received the bill from B & W Healthcare Assoc PA… The rational given by the requestor for the late bill is not consistent with the Rule above."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10 - 16, 2017	Professional medical services	$702.00	$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. 28 Texas Administrative Code §133.20 sets out the billing requirements for workers compensation medical claims.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

Issues

1. Has the requestor waived the right to MFDR?

Findings

1. The requestor is seeking $702.00 for professional medical services rendered from August 10, 2017 through August 16, 2017. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

   28 Texas Administrative Code §133.20 (j) states in pertinent part, "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.

   The requestor states in their position, "Our claims for the above dates of service were originally billed to the Employer…" Based on the above, the health care provider has waived the right to MFDR.

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 submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 31, 2019
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.