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
East Texas Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-2936-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As the third-party biller for ETMC, we received this account on 8/22/18. The employer has been waiting for drug test results to determine validity of the claim. At that time, (employer) told the hospital that he would be taking care of the bill. I have also included our letter that was sent to the employer to request payment."

Amount in Dispute: $8,032.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the requestor had to have known Texas Mutual was the carrier as they submitted an operative report (attachment) to Texas Mutual on 3/8/2018. The rationale 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
February 21, 2018	Outpatient Hospital Services	$8,032.94	$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 requirements of submission of medical bills by health care providers.
   - 29 - "The time limit for filing has expired"

Issues

1. Did the requestor waive their right to Medical Fee Dispute?

Findings

The requestor is seeking $8,032.94 for outpatient hospital services rendered on February 21, 2018. The requestor states in their position statement, … our letter that was sent to the employer to request payment."

28 Texas Administrative Code §133.20 (j) states,

> The health care provider may elect to bill the injured employee's employer… 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.

Based on the submitted documentation, the Division finds the requestor has waived their right to medical fee dispute.

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

		February 27, 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.