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
UHS OF TEXOMA INC

Respondent Name
EAST TEXAS EDUCATIONAL INSURANCE ASSN

MFDR Tracking Number
M4-19-3226-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 21, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[The injured employee] presented to the Emergency Room and provided his health insurance information which was BCBS. BCBS was billed and processed and paid claim on 05/09/2018 in the amount of $1,768.02. The patient called in his workers compensation insurance on 5/17 and after verifying the claim was still open the claim was billed. The claim was billed within 95 days once the correct insurance information was received."

Amount in Dispute: $6,881.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On 1/24/18 a request for Medical Records and bills was faxed to Texoma Medical Center. As notification was sent and received (see attached faxed request and confirmation), services were denied based on timely filing."

Response Submitted by: CAS, Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 23, 2018	Outpatient Hospital Services	$6,881.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 719 – PER RULE 133.20, A MEDICAL BILL SHALL NOT BE SUBMITTED LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 124 – DUPLICATE CHARGE

Issues

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

Findings

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 medical fee dispute resolution (MFDR).

Rule §133.307(c)(1)(A) further requires that a request for MFDR that does not meet any exceptions listed in Rule §133.307(c)(1)(B) be filed no later than one year after the dates of service in dispute.

The date of the services in dispute is January 23, 2018. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on February 21, 2019. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds the disputed services do not involve issues identified in Rule §133.307(c)(1)(B). The division concludes the requestor 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	March 15, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.