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 SERVICES OF TEXAS

MFDR Tracking Number
M4-19-4333-01

MFDR Date Received
June 3, 2019

Respondent Name
TRUCK INSURANCE EXCHANGE

Carrier's Austin Representative
Box Number 14

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"This bill is being disputed for no response for payment request and status of payment on bill… due to the non-response and age of this bill, this warrants an escalation to send this MFDR request."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 6, 2018	Ambulance Services	$695.79	$0.00

AUTHORITY

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 division provided a copy of the Medical Fee Dispute Resolution request to the insurance carrier's Austin representative, receipt acknowledged June 12, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Consequently, this decision is based on the information available at the time of review.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 234 – This procedure is not paid separately.
   - RG3 – Included in another billed procedure
   - P14 – Payment is included in another svc/procedure occurring on same day
   - R38 – Included in another billed procedure
   - R1 – Duplicate Billing
   - 18 – Duplicate Claim/Service

Issues

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

Findings

The Austin carrier representative for Truck Insurance Exchange is Farmers Insurance Group, who acknowledged receipt of a copy of the MFDR request on June 12, 2019. Pursuant to Rule §133.307(d)(1), if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision and the findings below are based on the information available at the time of review.

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 disputed date of service is April 6, 2018.

The request was received in the division's MFDR Section on June 3, 2019.

This date is later than one year after the disputed date of service.

Review of the submitted information finds the circumstances do not meet any of the exceptions listed in Rule §133.307(c)(1)(B). The MFDR request was thus not timely filed with the division. Consequently, the requestor has waived the right to MFDR for these services.

Conclusion

For the reasons above, the division finds the requestor has waived the right to MFDR for these services.
As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 16, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.