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
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4650-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 25, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"The transport … was submitted to Texas Mutual on February 26, 2019, eight days after the Workers Compensation Insurance information was released to Acadian Ambulance by the patient's attorney…"

RESPONDENT'S POSITION SUMMARY

"The bill was denied for untimely filing."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 5, 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A14 - AMB REIMB. IS BASED ON THE 28 TAC 134.203 AND TRAVIS CTY. COURT D-1-GN-15-004940 FINAL JUDGMENT HOLDING NO PYMTS>125% OF MEDICARE ARE DUE
   - P5 - BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT.
   - W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 138 - APPEAL PROCEDURES NOT FOLLOWED OR TIME LIMITS NOT MET
   - 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 29 - THE TIME LIMIT FOR FILING HAS EXPIRED
   - 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
   - 217 - THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

- 731 - PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.
- 879 - RULE 133.250(B) - HEALTH CARE PROVIDER SHALL SUBMIT THE REQUEST FOR RECONSIDERATION NO LATER THAN 10 MONTHS FROM THE DATE OF SERVICE
- 928 - HCP MUST SUBMIT DOCUMENTATION TO SUPPORT EXCEPTION TO TIMELY FILING OF BILL (408.0272). NOTIFICATION OF ERRONEOUS SUBMISSION NOT INCLUDED.

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 disputed date of service is April 5, 2018.

The request was received in the division's MFDR Section on June 25, 2019.

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

Review of the submitted information finds the services do not involve exceptions identified in Rule §133.307(c)(1)(B). Consequently, the MFDR request was not timely filed with the division. The requestor has thus waived the right to medical fee dispute resolution for these services.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has not established that additional reimbursement is due. 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	July 19, 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.