TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GALVESTON COUNTY HEALTH DISTRICT

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4778-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $1,162.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 5/6/19 received the bill from GALVESTON COUNTY HEALTH DISTRICT… The rational given by the requestor for the late bill is no consistent with the Rule above. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
November 19, 2018	A0428, A0425	$1,162.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

Issues

1. Are the disputed services eligible for review?

Findings

1. The requestor seeks reimbursement for HCPCS Codes A0428 and A0425 rendered on November 19, 2018. 28 TAC §133.307 (2) (c) (J) states, "Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions."

   Review of the documentation submitted by the requestor includes insufficient documentation to support that the requirements of 28 TAC §133.250 were met. As a result, the DWC finds that the disputed charges are not eligible for review.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 24, 2020 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all parties involved in the dispute at the same time the request is filed with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** along with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812