



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

GUADALUPE VALLEY HOSPITAL

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-20-0346-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 07, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached please find an EOB denying the above date of service. Patient presented to the Emergency Room with Upper Extremity Pain that the patient felt was an emergency to be seen. Per EMTALA our facility must treat the patient since he felt this was an emergency."

Amount in Dispute: \$626.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim [claim number] and GUADALUPE REGIONAL MEDICAL CENTER are participants in the Texas Star Network. (Attachment) ... Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: September 05, 2018, Codes 99070, 73030 and G0382-25, \$626.00, \$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- CAC-219 - Based on extent of injury
- 246 - The treatment/service has been determined to be unrelated to the extent of injury. Final

adjudication has not taken place

- CAC-W3 – In accordance with TDI-DWC Rule 134.804, This bill has been identified as a request for reconsideration or appeal
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 724 – No additional payment after a reconsideration of services. For information call 1-800-937-5824

### **Issues**

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

### **Findings**

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is September 05, 2018. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 07, 2019. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has 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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
November 7, 2019  
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 Texas Administrative Code §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 with the Division. **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.**