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
CITIZENS MEDICAL CENTER

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-20-0443-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please also find attached the Medical Fee Dispute Resolution Request, Refund letter from United Healthcare dated 10/24/2017. The EOB was issued 12/29/2017 reflecting the date of audit. This shows proof of timely filing prior to the 95th day after the date CMS was notified this is to be submitted to Texas Mutual as work related."

Amount in Dispute: $407.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim [claim number] and COUNTY OF VICTORIA CITIZENS 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

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2017	Codes G8978-GP CI, G8979-GP CI and 97163-GP	$407.02	$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:
    - A15 – The reimbursement for Health care services are subject to Texas Star Network contracts. A

certified WC HCN (Ins Code Ch 1305)

- CAC-246 – This non-payable code is for required reporting only
- CAC-45 – Charge exceeds Fee Schedule/Maximum allowable or Contracted/Legislated Fee arrangement
- 631 – PT, OT, or SP Code present without required non-payable G Code
- CAC-29 – The time limit for filing has expired
- 731 – Per 133.20(B) Provider shall not submit a medical bill later than the 95th day after the date the service
- 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 his 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 1-800-937-6824
- 929 – Not submitted timely per Rule 133.20(B) – Not later than 95th day after the date HCP is notified of erroneous submission of the medical bill

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Did the in-network healthcare provider render services to an in-network injured employee?

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 April 20, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 18, 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.

2. The DWC's medical fee dispute resolution program is authorized to resolve non-network and certain out-of-network medical fee disputes. Fee disputes resulting from care delivered through a network certified under Chapter 1305 of the Texas Insurance Codes are considered complaints. See Texas Insurance Code Sec. 1305.004(5). These complaints should be resolved through the Network complaint process outlined in Texas Insurance Code Chapter 1305, Subchapter I titled Complaint Resolution.

   Documentation found indicates that the health care in dispute was delivered through the Texas Star Network certified healthcare network. For that reason, the division's medical fee dispute section is not the appropriate venue to resolve this matter.

   Citizens Medical Center is hereby notified that the appropriate administrative remedy to resolve a Network medical fee dispute is the Network complaint process.

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

______________________________	______________________________	November 26, 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 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.