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
MMC LIVINGSTON

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-1369-01

Carrier's Austin Representative
Box 54

MFDR Date Received
FEBRUARY 3, 2020

REQUESTOR'S POSITION SUMMARY

"At the time, hospital staff was not advised by [employer] that services were due to work related injury or injuries. These charges were initially billed to and payed by the Claimant's commercial insurance carrier…It was the Carrier's contention that the 'the time limit for filing has expired. The Requestor appealed the Carrier's determination in the Request for Reconsideration on 12/18/19. Applicable mailing records indicate that it was received by Texas Mutual on the date of 12/20/19. The commercial remittance advice was attached as Proof of Timely Filing."

Amount in Dispute: $239.54

RESPONDENT'S POSITION SUMMARY

"In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2019	Outpatient Hospital Emergency Room Services	$239.54	$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. 28 Texas Administrative Code §134.503 sets out the reimbursement for compound medications
3. Explanation of Benefits:
   - CAC-29-The time limit for filing has expired.

- 731-Per Rule 133.20(B) providers shall not submit a medical bill later than the 95th day after the date the service.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 891-No additional payment after reconsideration.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- 920-Reimbursement is being allowed based upon a dispute.

Findings

The Division makes the following conclusions based upon the information and documentation presented to the Division to date. Even though all the evidence was not discussed, it was considered.

1. Did the carrier reimburse MMC Livingston for the disputed services?

MMC Livingston asserts that the carrier has not paid for the service in dispute. Review of the explanations of benefits provided finds that the carrier initially denied payment due to timely filing. Upon reconsideration, the carrier did not maintain its original denial and decided to issue a payment in the amount of $242.18 to MMC Livingston on March 23, 2020.

The Division concludes that the carrier changed its original final action and decided to reimburse MMC Livingston for the disputed amount.

MMC Livingston was notified by the Carrier and by the Division's medical fee dispute resolution program that the full amount in dispute was paid, however MMC Livingston has not taken the opportunity to refute the carrier's evidence or respond to the Division with additional information.

For that reason, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

The Division concludes that MMC Livingston has already been paid for the service in dispute. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, and pursuant to Texas Labor Code Section 413.031, the division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

Authorized Signature

		06/26/2020
Signature	Medical Fee Dispute Resolution Officer	Date

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, 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.