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
Essentia Health

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-20-1404-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been processed incorrectly and should have been processed as an outpatient service at a Critical Access Hospital (CAH) with less than 100 beds for Medicare locality out of the State of Wisconsin."

Amount in Dispute: $484.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Since the issue is one of reimbursement in a Texas workers' compensation claim, the reimbursement rate is based upon the Texas Medical Fee Guidelines and not that of another state. The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2018	Emergency Room/Urgent Care Services	$484.03	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service s included in the payment/allowance for another service/procedure that has already been adjudicated.

Issue

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

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Wisconsin to an injured employee with an existing Texas Workers' Compensation claim.

   The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307.

   Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, DWC concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

   28 TAC §133.307(c)(1) states a requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issues of compensability, extent of injury, liability, medical necessity or a refund request shall be filed no later than one year after the date(s) of service in dispute.

   The date of the service in dispute is April 26, 2018. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on February 4, 2020. 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 above.

   DWC concludes that the requestor has failed to timely file this dispute with DWC's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 requestor has not established payment 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, DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 12, 2020
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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together 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.