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
Hunt Regional Medical Center

Respondent Name
Travelers Property Casualty Company

MFDR Tracking Number
M4-21-0385-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
December 31, 2018

Response Submitted by
Travelers

REQUESTOR'S POSITION SUMMARY

"Requesting a Medical Fee Dispute due to Travelers Insurance not processing the 'First Report of Injury' claim per Administrative Code 124.1 a3 [sic]. Administrative Code 124.1 a3 [sic] states that an insurance carrier must accept a claim submitted as the first report of injury if no other report has been submitted. The claim must be reviewed and processed for payment consideration. Two bills were submitted by Hunt Regional Medical Center to Travelers Insurance on 2/20/2020 and 8/4/2020 and Travelers Insurance did not accept these claims. Nor did Travelers Insurance evaluate the claims to determine compensability."

RESPONDENT'S POSITION SUMMARY

"The Provider contends they are entitled to reimbursement for the disputed services from the Carrier. At the time of admission, the Employer indicated they would pay the bill directly in accordance with Rule 133.20j according to the Provider's billing cover letter to the Employer. The Employer has previously reimbursed the disputed services at full billed charges prior to the filing of this Request for Medical Fee Dispute Resolution under the Provider's billing directly to the Employer. As the Provider has already been reimbursed in full for the disputed services by the Employer, no additional reimbursement is due from the Carrier."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 10, 2020	99283-25	$657.00	$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. 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission by health care providers.
3. Neither party submitted EOBs for consideration in this dispute.

Issues

Did the requestor waive their right to Medical Fee Dispute?

Findings

The requestor seeks $657.00 for CPT Code 99283-25 rendered on January 10, 2020. The respondent states in their position statement, "The Employer has previously reimbursed the disputed services at full billed charges prior to the filing of this Request for Medical Fee Dispute Resolution under the Provider's billing directly to the Employer. As the Provider has already been reimbursed in full for the disputed services by the Employer, no additional reimbursement is due from the Carrier."

28 Texas Administrative Code §133.20 (j) states,

> The health care provider may elect to bill the injured employee's employer… Such billing is subject to the following:
>
> > (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:
> >
> > (A) prompt payment, as provided by Labor Code §408.027;
> >
> > (B) interest for delayed payment as provided by Labor Code §413.019; and
> >
> > (C) medical dispute resolution as provided by Labor Code §413.031.

Based on the submitted documentation, the Division finds the requestor has waived their right to medical fee dispute.

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 TLC §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 23, 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 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 TAC §141.1(d).

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