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
North Central Baptist Medical Center

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-21-1722-01

Carrier's Austin Representative
Box 19

MFDR Date Received
May 28, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Occasionally circumstances beyond the control of our organization occur and in this case, original claim was submitted to Blue Cross Blue Shield on 8/1/2020. Once we received patient's updated worker's compensation, we then submitted claim to Tristar Risk Management ton 12/11/2020."

Amount in Dispute: $1,075.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation the Division should dismiss the request for MFDR because there is no record of a reconsideration received of final action of an original bill which is required before provide can submit to MFDR."

Response submitted by: Injury Management Organization, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2020	Outpatient Hospital Services	$1,075.06	$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.

Issues

Did the requestor submit the medical claim within 95 days after notification of the workers' compensation coverage?

Findings

The requestor is seeking $1,075.06 for outpatient hospital services rendered in June 2020. Submitted documentation shows the medical claim was first submitted to Blue Cross Blue Shield and denied in August 2020 based on workers' compensation coverage.

A medical claim was submitted to the workers' compensation carrier, Tristar Risk Management, on December 14, 2020.

The applicable rule is found at 28 TAC §133.20 (b) which states in pertinent part, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

The December 14, 2020, claim submission is beyond ninety-five days of the notification from Blue Cross Blue Shield on August 1, 2020. No payment is recommended.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 24, 2021 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307,

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 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. **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.