# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
PROVIDENCE MEMORIAL HOSPITAL

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-23-1867-01

**Carrier's Austin Representative**
Box Number 54

**DWC Date Received**
March 31, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| November 11, 2021 | Hospital Outpatient | $1,340.82 | $0.00 |
| | **Total** | $1,340.82 | $0.00 |

"We did not receive accurate insurance information at the time of service from your member and recently learned that you are the correct payor. The facility made a good faith attempt to file our claim for medically necessary services within the specified timeframe. Based on the extenuating circumstance outlined below, we have established sufficient cause for you to reverse your denial for untimely filing and pay the referenced claims(s) at this time."

**Amount in Dispute:** $1,340.82

## Respondent's Position

"Texas Mutual has reviewed the DWC-60 submitted by SIERRA MEDICAL CENTER.

Texas Mutual on 5/23/2022 received the original bill from SIERRA MEDICAL CENTER …

On 8/9/2022 Texas Mutual received the appeal bill from SIERRA MEDICAL CENTER which

included the notice of erroneous billing from Aetna Insurance. The notice of erroneous billing was dated 12/21/201 and 95 days from that date was 03/26/2022. Neither the original bill or appeal bill were received by that date."

**Response Submitted by:** Texas Mutual Workers Compensation Insurance

## Findings and Decision

### Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

### Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 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 this claim was processed properly
- CAC-29 The time limit for filing has expired
- DC4 – No additional reimbursement allowed after reconsideration. For information call (888) 532-5246
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 731 – Per 133.20(B) Provider shall not submit a medical bill alter than the 95$^{th}$ day after the date the service
- 929 – Not submitted timely per Rule 133.20(B) not later than 95$^{th}$ 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?

### Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division 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 November 11, 2021. The request for medical fee dispute resolution was received on March 31, 2023. 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; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

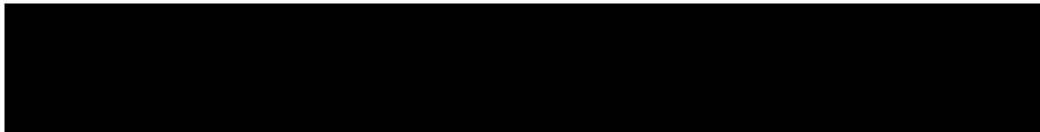
The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds that no additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

**Authorized Signature**



| Signature | Medical Fee Dispute Resolution Officer | May 11, 2023<br>Date |
|---|---|---|

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must 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*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.