TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baptist Medical Center

Respondent Name
Bexar County

MFDR Tracking Number
M4-23-2531-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
May 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 13, 2020	450/12013	$0.00	$0.00
August 13, 2020	450/99284	$636.88	$0.00
	Total	$636.88	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated August 7, 2022 that states, "This claim has a service date of 08/13/2020. The patient initially presented as self-pay and it was only 08/23/2020 when we found out that the patient has VHA OFFICE OF. It was billed to your office on 08/24/2020 Hence, this claim was billed timely."

Amount in Dispute: $636.88

Respondent's Position

"It is the carrier's position that this Medical Dispute is not timely filed per DWC Rule 133.307 (c)(1)(A) which states, 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.' In addition, this bill was reconsidered and allowed on 07-14-2021 with a recommended allowance of $953.20. Check number 12988259 was issue 07-19-2021. It is the carrier's position that no

additional allowance is due. $953.20 is the correct fee schedule allowance..."

Response submitted by: Novare LLC

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 (TAC) §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:

- 29 – The time limit for filing has expired.
- 4271 – Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.
- W3 – Additional payment made on appeal/reconsideration (TXWC)
- 5056 – Based on receipt of additional information and/clarification, we are recommending further payment be made for the above noted procedure(s).

Issues

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

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered in August 2020. The insurance carrier denied the claim originally as not filed timely but upon reconsideration a payment of $953.22 was made on July 14, 2021.

   DWC Rule 28 TAC §133.307(c)(1) states:

   "Timeliness. 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 division receives the request.

   (A) A request for medical fee dispute resolution 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.

(B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review; the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The date of the service in dispute is August 13, 2020. The request for medical dispute resolution was received at the Division on May 30, 2023.

Review of the submitted documentation found insufficient evidence to support that the requestor met any of the exceptions detailed above. The requestor has waived their right to MFDR.

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 the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 6, 2023 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.