



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baptist Medical Center

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-23-3072-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

August 3, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 15, 2020	250	\$58.00	\$0.00
January 15, 2020	350/70450	\$4915.00	\$0.00
January 15, 2020	350/71250	\$5649.00	\$0.00
January 15, 2020	360/72125	\$5105.00	\$0.00
January 15, 2020	450/96374	\$821.00	\$0.00
January 15, 2020	450/99285/25	\$5616.00	\$0.00
January 15, 2020	636/j3010	\$7.00	\$0.00
Total		\$1670.74	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "Please note that the patient originally presented with Humana as the primary payer. We submitted our claim to them it was denied due to this is a worker's comp incident. Multiple attempts were made to obtain the worker's comp information without success. The patient then obtained an attorney and all communication went through them. A call was made to the attorney on 01.24.2023 and we were then told the case had been closed and the patient was looking into obtaining a new attorney. Again, multiple attempts were made to contact the patient for updated information. The patient called us on 03.09.2023 and provided Texas Mutual as the worker's comp carrier. We submitted our claim to you on 03.14.2023, resulting in the denial for untimely filing."

Amount in Dispute: \$1670.74

Respondent's Position

"One year from disputed date 01/15/2020 would have been 01/14/2021. The TDI/DWC date stamp lists the received date as 08/03/2023 on the requestor's DWC-60 packet, a date greater than one year. The requestor has waived its right to DWC MDR. Our position is that no payment is due."

Response submitted by: Texas Mutual

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.
2. [28 TAC §133.20](#) sets out the billing requirements of professional medical claims.

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 – Time limit for filing claim/bill has expired.
- 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 later than the 95th day after the date the service.
- 928 – HCP must submit documentation to support exception to timely filing of bill (408.0272). Notification of erroneous submission not included.

Issues

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

Findings

1. The requestor is seeking payment for outpatient emergency room services rendered on January 15, 2020. The insurance carrier denied the disputed services as not submitted within 95 days.

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 disputed date of the service is January 15, 2020. The request for medical dispute resolution was received by the division on August 3, 2023.

A review of the submitted documentation found insufficient evidence to support a claim was submitted to another payer prior to the workers' compensation carrier. Documentation did not support an exception as described 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 requestor 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

_____	_____	August 23, 2023
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 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 electrónico CompConnection@tdi.texas.gov.