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
North Central Baptist Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-24-0527-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 31, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 21, 2021	A9150	Left blank	$0.00
February 21, 2021	70450	Left blank	$0.00
February 21, 2021	72125	Left blank	$0.00
February 21, 2021	99284	Left blank	$0.00
	Total	$1068.46	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR). They did submit a copy of their reconsideration that states, "Every effort is made at the time of service to obtain complete and accurate insurance information from your member in order to timely bill and collect payment for the above referenced services. Occasionally, circumstances reasonably beyond the control of our organization occur and it is discovered that the information is inaccurate. We are requesting to re-review the claim and consider for payment based on extenuating circumstances."

Amount in Dispute: $1068.46

Respondent's Position

"One year from disputed date of service 02/21/2021 would have been 02/21/2022. The TDI/DWC date stamp lists the received date as 10/31/2023 on the requestor's DWC-60 packet, a date greater than one year. The requestor has waived its right to DWC MDR."

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.

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-18 – Exact duplicate claim/service.
- 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.
- DC7 – Duplicate appeal. Network contract applied by WorkWell, TX Network.
- 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 in February of 2021. The insurance carrier denied the disputed services as not submitted timely and as a duplicate billing.

   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 February 21, 2021. The request for medical dispute resolution was received at the Division on October 31, 2023.

   Review of the submitted documentation found insufficient evidence to support an exception as 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	November 30, 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.