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
Coon Memorial Hospital

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-24-0872-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 15, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 10, 2023	Emergency Room	$1,014.00	$0.00
	Total	$1,014.00	$0.00

Requestor's Position

"On 6/22/2023, I called Corvel to see if there is a workers comp claim filed & they said there was not a claim filed yet, so I mailed a bill to the patient's employer,"

Amount in Dispute: $1,014.00

Respondent's Position

"The HCP has failed to submit valid proof of timely filing in accordance with the rules listed above."

Response submitted by: CorVel

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 guidelines for medical bill submission by Health Care Provider.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 29 – Time limit for filing claim/bill has expired.
- RZ0 – Status Indicator: Q4 Packaged Lab service.
- P14 – Payment is included in another svc/procedure occurring on same day.
- W3 – Appeal/Reconsideration.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for Emergency Room Services rendered in June, 2023. In their position statement the requestor indicates, "On 6/22/2023, I called Corvel to see if there is a workers comp claim filed & they said there was not a claim filed yet, so I mailed a bill to patients employer."

   DWC Rule 28 TAC 133.20 (j) states in pertinent part,

   The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following:

   (1) A health care provider who elects to submit medical bills to an employer **waives, for the duration of the election period,** the rights to:

   (A) prompt payment, as provided by Labor Code §408.027;

   (B) interest for delayed payment as provided by Labor Code §413.019; and

   (C) **medical dispute resolution** as provided by Labor Code §413.031.

   Based on the submitted information, 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

______________________	______________________	January 12, 2024
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 electronico CompConnection@tdi.texas.gov.