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**
EMERGENCY PHYSICIANS

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-24-1149-01

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

**DWC Date Received**
January 22, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| August 19, 2021 | Hospital Outpatient and Emergency visit | $8.058.56 | $0.00 |
| | **Total** | $8,058.56 | $0.00 |

## Requestor's Position

"Requesting a reconsideration request for [injured employee] Claim [claim number] for dos 8/19/2021 Claim was last denied as duplicate and also denied for timely filing. Physician bill of $995.76 was just paid and service was same day of 8/19/2021 with same 99284 billed, but facility and physician are two separate charges and both have their own tax ids/NPI, facility bill was also billed as 99284 but has a tax id of ..."

**Amount in Dispute:** $8,058.56

## Respondent's Position

"One year from disputed date of service 08/19/2021 would have been 08/19/2022. The TDI/DWC date stamp lists the received date as 01/22/2024 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 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 (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-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 later than the 95th day after the date the service
- 928 – HCP must submit documentation to support exception to timely filing of bill (406.0272) Notification of Erroneous submission
- CAC-18 – Exact duplicate claim/service
- DC7 – Duplicate appeal. Network contract applied by WorkWell, TX Network call (888) 532-5246 for reconsideration discussion
- 879 – Rule 133.250 (B) health care provider shall submit the request for reconsideration no later than 10 months from the date of service

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 August 19, 2021. The request for medical fee dispute resolution was received on January 22, 2024. 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 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**

| [redacted] | | February 8, 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.