



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baptist Health System

**Respondent Name**

City of San Antonio

**MFDR Tracking Number**

M4-24-1288-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

February 12, 2024

### Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due    |
|------------------|-------------------|-------------------|---------------|
| July 15, 2021    | 80053             | \$0.00            | \$0.00        |
| July 15, 2021    | 85025             | \$0.00            | \$0.00        |
| July 15, 2021    | 85610             | \$0.00            | \$0.00        |
| July 15, 2021    | 85730             | \$0.00            | \$0.00        |
| July 15, 2021    | 71045             | \$146.98          | \$0.00        |
| July 15, 2021    | 0479T             | \$952.36          | \$0.00        |
| July 15, 2021    | 0480T             | \$0.00            | \$0.00        |
| July 15, 2021    | 01999             | \$0.00            | \$0.00        |
| July 15, 2021    | J0690             | \$0.00            | \$0.00        |
| July 15, 2021    | J2270             | \$0.00            | \$0.00        |
| July 15, 2021    | J2704             | \$0.00            | \$0.00        |
| July 15, 2021    | J32010            | \$0.00            | \$0.00        |
| July 15, 2021    | J3301             | \$0.00            | \$0.00        |
| July 15, 2021    | J7120             | \$0.00            | \$0.00        |
| <b>Total</b>     |                   | <b>\$1,099.34</b> | <b>\$0.00</b> |

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "These services were provided in good faith and should be paid accordingly. Every effort is made at the time of service to bill the claim in timely manner and collect payment for the service rendered to your member."

**Amount in Dispute:** \$1,099.34

### **Respondent's Position**

"The request for recommendation on date of service 7/15/2021 and 7/16/2021 received by the division on 2/20/2024 is past the time frame for requesting MDR."

**Response submitted by:** Injury Management Organization

### **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.
- 285 – Appeal procedures not followed.
- W3 – TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.

#### Issues

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

#### Findings

1. The requestor is seeking payment for outpatient hospital services rendered in July of 2021. The insurance carrier denied the claim based on non-timely submission of medical bill.

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 service in dispute is July 15, 2021. The request for medical dispute resolution was received at the Division on February 12, 2024.

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

|           |  |                |
|-----------|--|----------------|
| _____     | _____                                  | March 11, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).