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
VHS Harlingen Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-24-1905-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 13, 2023	0250	$45.00	$0.00
June 13, 2023	0450	$5,996.00	$0.00
June 13, 2023	0636	$48.00	$0.00
	WC ADJUSTMENT	$-5,009.28	$0.00
	Total	$1,079.72	$0.00

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed the carrier, but the bill was underpaid. However, despite the Hospital's efforts and Request for Reconsideration sent to the carrier, the carrier has not rendered proper payment."

Amount in Dispute: $1079.72

Respondent's Position

"As of today, Texas Mutual has not received any billings from VHS Harlingen Hospital. TIN #45-2662980, for date of service 06/13/2023. VHS Harlingen has not provided proof of how they submitted billing. 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).

Statues 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 requirements of medical bill submission.

Denial Reasons

Neither party submitted any remittance notices to support adjudication of the claim.

Issues

1. Did the requestor support claim was submitted to insurance carrier or employer?

Findings

1. The requestor is seeking reimbursement for outpatient emergency room services rendered in June of 2023. The insurance carrier states in their position that they have not received any bills from requestor.

   Review of the submitted documentation found on October 13, 2023, Valley Baptist Medical Center in Harlingen submitted a "Payment Demand Letter" to WORKERS COMP ADMIN, 818 FM 509, Harlingen, TX 78550-1855. This address is associated with the employer of the injured worker. The submitted documentation supports the requestor billed the employer not the insurance carrier.

   DWC Rule 28 TAC §133.20 (j) states, "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 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 additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		May 16, 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.