



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

BioCare Health

**Respondent Name**

American Interstate Insurance Co

**MFDR Tracking Number**

M4-24-2033-01

**Carrier's Austin Representative**

Box Number 47

**Date Received**

May 20, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 26, 2020	Surgical Implants	\$19,613.75	\$0.00
<b>Total</b>		\$19,613.75	\$0.00

### Requestor's Position

"My client timely filed the attached mailed packet to the carrier. My client received the attached zero pay Explanation of Bill Review back in 2020. Over the course of the next two years, my client continued to file and appeal this claim and has tried numerous times to get answers on the phone from Amerisafe, but to no avail. Also, find the attached certification approval, approved by you, that specifically outlines that my client will be billing for the implants on this case. The hospital where this surgery was performed has gone through consolidation of vendors. As such, my clients implant bill would have gone directly to the hospital, but in this case, had to bill the carrier directly. My client only anticipates getting their bill paid at cost, plus 20%. In the state of Louisiana under workers compensation Law: LAC40:5115, the carrier is responsible for the invoice cost of the plastic and metallic implants plus twenty (20) percent. My client has, to date, not received payment from the carrier, I am sure you are aware that according to the LAC 40:5115 and to the LA OWC MTG, the carrier has 60 days to pay the claims received for medical care."

**Amount in Dispute:** \$19, 613.75

## Respondent's Position

"AMERISAFE Risk Services Inc received the MDR associated with the bill listed above. The original bill was received on July 20, 2020. The bill was denied by bill review indicating that the facility bill had not been received when BioCare Health submitted their bill and DME charges can only be processed upon receipt of the facility bill. The facility submitted their bill on September 14, 2022; however, BioCare Health did not resubmit their bill again until April 5, 2024 for the first reconsideration and on May 21, 2024 for the second reconsideration. Both reconsiderations were denied for timely filing. Per Texas Reconsideration Process, reconsiderations should be submitted within 10 months from the date of service. The reconsideration was not submitted timely by the provider. A copy of the EORs are enclosed."

**Response Submitted by:** Amerisafe Risk Services Inc

## 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](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

### Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 28 (16) – The reduction was made for the reasons indicated in note below or on the attached note or letter.
- 16:28 – Claim/service lacks information or has submission/billing error(s).
- @G (W3) – No additional reimbursement allowed after review of appeal/reconsideration.
- AB (97) – The payment for this service is bundled into the payment of other services.
- XE (P12) - Bills are not payable if the number of days between the date of service/discharge as the submission date exceeds 10 months.
- TX 97 – The benefit for this service is included in the payment /allowance for another service/procedure that has already been adjudicated.
- TX P12 – Workers' compensation jurisdictional fee schedule adjustment.
- TX W3 – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- Note: We haven't received the facility bill yet & can only process DME charges after receiving facility bill. Bill is over 4 years old. Denied for late filing.

## **Issues**

1. Under what authority is the request for medical fee dispute resolution considered?
2. Has the requestor waived their right to medical fee dispute resolution?

## **Findings**

1. The requestor is a health care provider that rendered disputed services in the state of Louisiana to an injured employee with an existing Texas Workers' Compensation claim. The DWC finds the following:
  - The health care provider was dissatisfied with the insurance carrier's final action.
  - The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration.
  - The health care provider has requested medical fee dispute resolution under 28 TAC §133.307.

Because the requestor has sought the administrative remedy under 28 TAC §133.307 for resolution of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. The requestor seeks payment in the amount of \$19,613.75 for medical services provided on June 26, 2020.

28 TAC §133.307 (c) (1) states in the pertinent part, "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."

The service in question was performed on June 26, 2020, The medical fee dispute was received by the Division on May 20, 2024. This date is more than a year following the in-question date(s) of service.

28 TAC §133.307 (c) (1) (A) states, "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."

A review of the submitted documentation finds that the disputed service(s) do/does not involve issues identified in 28 TAC §133.307 (c) (1) (B). The Division concludes that the requestor has failed to timely file this dispute with the Division; 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.

The Division finds the requester has not established that reimbursement of is due.

## Order

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

### Authorized Signature

_____	_____	June 21, 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). The Division must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to the Division using the contact information on the form or the field office handling the claim. If you have questions about the DWC Form-045M, 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 the Division. **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 prefieres 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).