TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ST DAVIDS MEDICAL CENTER

Respondent Name
UNIVERSITY OF TEXAS SYSTEM

MFDR Tracking Number
M4-17-0057-01

Carrier's Austin Representative
Box Number 46

MFDR Date Received
September 06, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above referenced claim has been referred to us by ST. DAVIDS MEDICAL CENTER. We are in receipt of a denial for timely filing and are submitting a Medical Fee Dispute for payment … Firstly, we have attached the registration sheet showing that at the time of admission, the patient stated that she had coverage with BCBS TX. (Exhibit 1)

Secondly, we have attached the remit form BCBS of TX which will show that they received the claim on January 12, 2015 and issued a payment for $21, 175.06 on January 27, 2015. This should be sufficient proof that the claim was sent to the incorrect carrier within 95 days from the date of discharge. (Exhibit 2)."

Amount in Dispute: $54,963.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "St. David's has not filed a timely request for medical fee dispute resolution. Accordingly, the Division of Workers' Compensation does not have jurisdiction to review the dispute and it should dismiss the request.

There are only two dates of service in dispute, which are 1/06/16 and 1/07/15. Therefore, St. David's was required to request dispute resolution no later than 1/07/16. See Division Rule 133.307(c). It filed its request on 09/06/16, or nearly eight months too late."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 06, 2015 through January 07, 2015	Outpatient Hospital Services	$54,963.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

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 shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section 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 January 06, 2015 to January 07, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 06, 2016. 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 with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		9/27/16
Signature	Medical Fee Dispute Resolution Officer	Date
		9/27/16
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall 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*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.