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
MHHS Hermann Hospital

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-17-2849-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 26, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital's bill has been denied by Liberty Mutual Insurance ('Liberty Mutual') for because of timely filing. Timely filing was the denial reason received by the Hospital, and after we requested Liberty Mutual to reconsider the denial and issue reimbursement, the denial reason remained the same."

Amount in Dispute: $48,556.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill for services of January 23, 2016 to January 25, 2016 was received on September 20, 2016 and denied as not filed within 95 days as required by 133.20 of the TX rules. The dispute packet information states that this bill should fall under one of the exceptions provided in Labor Code 408.0272."

Response Submitted by: Liberty Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2016 through January 25, 2016	Outpatient Hospital Services	$48,556.58	$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:
   - BF06- Date(s) of service exceed (95) day time period for submission per Rule 408.027 and Bulletin No. B-

0037-05A

- Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
- ZC72 – In the event this payment needs to be returned to the payer, please return the check to PO Box 8011, Wausau, WI 54402. To submit a dispute or appeal, please see the address in the upper left hand corner of this eob

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 outpatient hospital services. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on January 23, 2016 through January 25, 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

		6/28/2017
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 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.