



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

DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name

EAST TEXAS EDUCATIONAL INSURANCE ASSOCIATION

MFDR Tracking Number

M4-18-2682-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

March 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for review with the request.

Amount in Dispute: \$298.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that the facility has failed to prove that they were not aware of where to file the medical bills and for this reason we feel denial based on timely filing should be maintained."

Response Submitted by: CAS, Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 2, 2017	Outpatient Hospital Services	\$298.76	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
 - 719 – PER RULE 133.20, A MEDICAL BILL SHALL NOT BE SUBMITTED LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE.
 - 307 – PER 133.250, A RECONSIDERATION SHALL NOT BE SUBMITTED LATER THAN 11 (<07/01/12) OR 10 (>=07/01/12) MONTHS FROM THE DATE OF SERVICE.
 - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
 - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

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 February 2, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 26, 2018. 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 on the information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	April 6, 2018
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 Rule §133.307.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWCO45M) in accordance with the form’s instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.