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
MEMORIAL HERMANN HOSPITAL

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-0481-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
September 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the claim is unreported and the carrier has refused to accept the bill and medical records as a First Report of a claim per Texas Rule 124.1A3."

Amount in Dispute: $246,801.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Office … will maintain our denial for 29-Time limit for filing has expired. Furthermore … this dispute was not filed pursuant to Rule 133.307 … requestor failed to submit their dispute within one (1) year from the date of service. The Office also would like to note that the requestor has not submitted a Request for Reconsideration pursuant to Rule §133.250"

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 6, 2017 to February 13, 2017	Inpatient Hospital Facility Services	$246,801.39	$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
   - 4271 - PER TX LABOR CODE SEC. 413.016, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) requires that a requestor shall timely file the request with the division's MFDR Section or waive the right to medical fee dispute resolution (MFDR).

   Rule §133.307(c)(1)(A) further requires that a request for MFDR that does not meet any exceptions listed in Rule §133.307(c)(1)(B) be filed no later than one year after the dates of service in dispute.

   The dates of the services in dispute are from February 6, 2017 to February 13, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 18, 2018. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds the disputed services do not involve issues identified in Rule §133.307(c)(1)(B). The division concludes the requestor 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	November 8, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

______________	Matthew Zurek	November 8, 2018
Signature	Deputy Commissioner for Health and Safety	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 DWC045M) 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.