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
Amerisure Insurance Co

MFDR Tracking Number
M4-19-0833-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As of right now, the claim is denied for Authorization for this Workers Compensation claim and Emergency admit doesn't require Authorization and these days were approved per Unimed, a company that did authorizations for Amerisure back on 11/3/2016."

Amount in Dispute: $221,669.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the attached medical fee dispute from MHHS Hermann Hospital regarding dates of service 11-2-16/11-16-16 for an inpatient hospitalization. Carriers position is that the bill was properly denied based on the lack of preauthorization per rule 134.600. …Carrier also dispute these charges because the requestor did not seek Medical Dispute Resolution within one year of the date of service as required by Rule 133.307(c)(1)(a)."

Response Submitted by: Amerisure

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2 – 16, 2016	Inpatient Hospital Services	$221,669.93	$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 health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 39 – Services denied at the time authorization/pre-certification was requested

Issue

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

Findings

1. The requestor is seeking reimbursement for inpatient hospital services rendered from November 2 – 16, 2016. The respondent states in their position statement, "Carrier also dispute these charges because the requestor did not seek Medical Dispute Resolution within one year of the date of service as required by Rule 133.307(c)(1)(a)."

   28 TAC 133.307 (c)(1) states in pertinent part, "Timeliness. A requestor shall timely file 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.

   The date of the service in dispute is November 2 – 16, 2016. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on October 15, 2018. This date is later than one year after the date(s) of service in dispute.

   The respondents' position is supported as the requestor has failed to timely file this dispute with the Division's MDR Section. Consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute.

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

		January 11, 2019
Signature	Medical Fee Dispute Resolution Officer	Date
		January 11, 2019
Signature	Deputy Commissioner	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, 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. **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.