



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DETAR HEALTHCARE SYSTEM

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-19-4238-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

MAY 24, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above patient was admitted via the emergency room with complication from work related injuries date back on 01/15/02. Texas Mutual denied claim due to lack of precertification for the Inpatient stay, however medical records were sent to prove medical necessity and claim decision was upheld."

Amount in Dispute: \$55,956.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from disputed date of service listed above is 03/30/2018. The TDI/DWC date stamp lists the received date as 06/03/2019 on the requestor's DWC-60 packet, a date greater than one year from 03/30/2017. The requestor has waived its right to DWC MDR. No payment is owed."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2017 thru March 30, 2017	Inpatient Hospital Services	\$55,956.44	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 services in dispute were reduced / denied by the respondent with the following reason code:
 - CAC-197-Precertification/authorization/notification absent.
 - 240-Preauthorization not obtained.
 - CAC-18-Exact duplicate claim/service.

- CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217-The value of this procedure is included in the value of another procedure performed on this date.
- 224-Duplicate charge.

Issue

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

Findings

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 dates of service in dispute are March 24, 2017 thru March 30, 2017. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on May 24, 2019. 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 for these services.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute for those dates have not been addressed.

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 services in dispute.

Authorized Signature

		06/24/2019
Signature	Medical Fee Dispute Resolution Officer	Date

		06/24/2019
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 MDR 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.