



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

METROPOLITAN ANESTHESIA CONSULTANTS, LLP

Respondent Name

TASB RISK MANAGEMENT FUND

MFDR Tracking Number

M4-19-4701-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

June 26, 2019

Response Submitted By

TASB Risk Fund

REQUESTOR'S POSITION SUMMARY

"We have appealed for timely filing, coding correction and given ample proof of timely filing via certified mail tracking number..."

RESPONDENT'S POSITION SUMMARY

"Metropolitan Anesthesia Consultants request for medical dispute resolution (MDR) has been submitted past filing limits for an MDR as per Rule 133.307."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 30, 2018	Professional Medical Services	\$5,112.00	\$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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:
 - B22 – This payment is adjusted based on the diagnosis.
 - B15 – This service/procedure requires that a qualifying service/procedure be received and covered.
 - 29 – The time limit for filing has expired
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3 – Additional payment made on appeal/reconsideration.

Issues

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

Findings

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 disputed date of service is January 30, 2018.

The request was received in the division’s MFDR Section on June 26, 2019.

This date is later than one year after the disputed date of service.

Review of the submitted information finds the services do not involve issues identified in Rule §133.307(c)(1)(B). Consequently, the MFDR request was not timely filed with the division. The requestor has thus waived the right to medical fee dispute resolution for these services.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has waived the right to medical fee dispute resolution. As a result, the amount ordered is \$0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 19, 2019
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. The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.