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
TOPS Specialty Hospital

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-19-4722-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $4,525.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2018	63650	$4,525.98	$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:
   - 892 – Billed date exceeds 95 days for dos
   - 29 – The time limit for filing has expired
   - B12 – Re-evaluated additional payment recommended
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issue

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

Findings

The Austin carrier representative for Insurance Co of the State of the State of PA is Flahive, Ogden & Latson. The carrier rep acknowledged receipt of the copy of this medical fee dispute on July 9, 2019. 28 TAC §133.307 states, in relevant part:

> (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
>
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of the insurance carrier to date. The insurance carrier failed to respond within the timeframe required by §133.307(d)(1). DWC will base its decision on the information available.

The rule specific to filing a request for MFDR is found in 28 TAC §133.307(c)(1) which requires request for medical fee dispute shall be filed no later than one year after the date(s) of service.

The date of the service in dispute is April 25, 2018. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 1, 2019.

This date is later than one year after the date(s) of service in dispute.

An exception to the one year filing requirement is available per provisions of 28 TAC §133.307(c)(1)(B) if an issue of compensability, extent or medical necessity was appealed and the request for MFDR was filed 60 days after the date the requestor receives the final decision.

Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B).

DWC concludes that 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

DWC finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute 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, DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 25, 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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 DWC. **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.