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
Texas Institute for Surgery

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-19-4975-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the facility did not request separate reimbursement for implants."

Amount in Dispute: $5,374.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2018	23430	$5.374.80	$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:
   - 510 – Payment determined
   - R25 – Procedure billing restricted/see state regulations

Issue

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

Findings

The Austin carrier representative for Ace American Insurance Co is Downs Stanford who acknowledged receipt of the copy of this medical fee dispute on July 30, 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** [emphasis added]. 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 for the carrier representative to date. DWC concludes the insurance carrier failed to respond within the timeframe required by §133.307(d)(1). DWC will base its decision on the information available.

1. The requestor is seeking $5,374.80 for outpatient hospital services rendered July 18, 2018. The insurance carrier reduced the approved payment based on state regulations.

   28 TAC §133.307(c)(1) states requests for MFDR shall be filed no later than one year after the date(s) of service unless a related compensability, extent of injury or liability.

   The date of the service in dispute is July 18, 2018. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 22, 2018.

   This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues of compensability, extent or liability. Based on this no exception was found.

   DWC concludes that the requestor has failed to timely file this dispute with the DWC'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

		October 4, 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 TAC §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 the 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.