



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

UT HEALTH CENTER TYLER

Respondent Name

UNIVERSITY OF TEXAS SYSTEM

MFDR Tracking Number

M4-20-0007-01

Carrier's Austin Representative

Box Number 46

MFDR Date Received

September 3, 2019

Response Submitted By

IMO, Injury Management Organization

REQUESTOR'S POSITION SUMMARY

"This DOS has not been paid."

RESPONDENT'S POSITION SUMMARY

"acceptable proof of timely filing was not submitted. Therefore... the health care provider... has forfeited the right to reimbursement due to untimely submission of the medical bill for the service dispute."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 6, 2018 to August 16, 2018	Physical Therapy	\$650.58	\$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 (DWC).

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:
 - W3 – RECONSIDERATION
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
 - 18 – DUPLICATE CLAIM/SERVICE
 - 18 – EXACT DUPLICATE CLAIM/SERVICE
 - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE
 - 306 – BILLING IS A DUPLICATE OF OTHER SERVICES PERFORMED ON SAME DAY

Issues

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

Findings

28 Texas Administrative Code §133.307(c)(1) requires requestors to timely file medical fee dispute resolution (MFDR) requests with DWC’s MFDR Section or waive the right to MFDR.

28 TAC §133.307(c)(1)(A) further requires that a request for MFDR that does not meet any exceptions listed in 28 TAC §133.307(c)(1)(B) be filed no later than one year after the dates of service in dispute.

The disputed service dates extend from August 6, 2018 to August 16, 2018.

The request was received in DWC’s MFDR Section on September 3, 2019.

This date is later than one year after the dates of service in dispute.

Review of the submitted information finds the circumstances do not involve any of the exceptions listed in 28 TAC §133.307(c)(1)(B).

DWC concludes the requestor failed to timely file this dispute with DWC’s MFDR Section. Consequently, the requestor has waived the right to medical fee dispute resolution.

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 requestor has not established that additional reimbursement is due. 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, DWC hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 13, 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. The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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