TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
HERITAGE PARK SURGICAL HOSPITAL

**Respondent Name**
OLD REPUBLIC INSURANCE COMPANY

**MFDR Tracking Number**
M4-20-0009-01

**Carrier's Austin Representative**
Box Number 44

**MFDR Date Received**
September 4, 2019

**Response Submitted By**
No response received from insurance carrier

## *REQUESTOR'S POSITION SUMMARY*

"billed diagnosis… is related to accepted condition which documentation was provided timely."

## *RESPONDENT'S POSITION SUMMARY*

The insurance carrier did not submit a response for consideration in this review.

## *SUMMARY OF DISPUTE*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| June 22, 2018 | Emergency Department and Diagnostic Services | $2,047.00 | $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 (DWC).

### 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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 226 -INFORMATION REQUESTED FROM THE BILLING/RENDERING PROVIDER WAS NOT PROVIDED OR NOT PROVIDED TIMELY OR WAS INSUFFICIENT/INCOMPLETE.
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - 5205 - CANNOT REVIEW BILL WITHOUT MEDICAL NOTES FOR DATE(S) OF SERVICE. PLEASE SUBMIT MEDICAL NOTES WITH THE BILL TO EXPEDITE PROCESSING.
   - 5085 – PAYMENT IS DENIED AS THE BILLED DIAGNOSIS IS NOT ALLOWED IN THIS CLAIM.
   - 5083 – OP REPORT/MEDICAL RECORDS ARE REQUIRED FOR REVIEW. PLEASE RE-SUBMIT BILL WITH PROPER INFORMATION FOR FURTHER PROCESSING.

**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 date of service is June 22, 2018.

The request was received in DWC's MFDR Section on September 4, 2019.

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

Review of the submitted information finds the circumstances do not involve any of the exceptions listed in 28 TAC §133.307(c)(1)(B). Consequently, the MFDR request for date of service June 22, 2018 was not timely filed with DWC. The requestor has thus waived the right to MFDR for these services.

**Conclusion**

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC 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 | October 18, 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.