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 Health Alliance

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-20-0074-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 12, 2019

Response Submitted by:
The Hartford

REQUESTOR'S POSITION SUMMARY

"The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

RESPONDENT'S POSITION SUMMARY

"Dates of service in dispute were process in accordance with Texas Workers' Compensation Guidelines 28 TAC §134.203 (b)(1) & (c), 28 TAC §134.403."

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount in Dispute	Amount Ordered
July 9 – 30, 2018	Outpatient Therapy Services	$144.47	$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.

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:
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
   - 906 – In accordance with clinical based coding edits
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issue

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

Findings

1. 28 TAC §133.307(c)(1) states a request for medical fee dispute resolution that does not involve compensability, extent of injury, liability, medical necessity or a refund shall be filed no later than one year after the date(s) of service in dispute.

   The date of the service in dispute is July 9 – 30, 2018. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 12, 2019.

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 identified in §133.307, subparagraph (B). 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 17, 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 TAC §141.1(d).

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