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
MADISON ST JOSEPH HEALTH

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-20-0175-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 19, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"The Workers' Compensation insurance carrier performed a review of this claim and made the determination that the documentation and file did not support an emergency. We are now seeking dispute resolution in an effort to have the claim adjudicated so we can proceed with billing the responsible party."

RESPONDENT'S POSITION SUMMARY

"The employee's clinical presentation was not emergent. The physical exam and MRI reports confirmed it was not emergent."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 19, 2018	Outpatient Hospital Services	$8,224.00	$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.
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Issues

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

Findings

Rule 28 Texas Administrative Code §133.250(i) provides that "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution…"

No information was presented by the requestor to support that the health care provider asked for reconsideration of the bill from the insurance carrier before requesting medical fee dispute resolution (MFDR). The request is therefore not eligible for review.

Rule 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.

Rule 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 August 19, 2018.

The request was received in DWC's MFDR Section on September 19, 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 Rule 28 TAC §133.307(c)(1)(B). Consequently, the MFDR request for date of service August 19, 2018 was not timely filed with DWC. The requestor has thus waived the right to medical fee dispute resolution 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.

This request is not eligible for medical fee dispute resolution because the provider failed to first request reconsideration from the insurance carrier. Furthermore, the requestor has forfeited the right to MFDR for failure to ask for MFDR within one year of the date of service. Consequently, 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 11, 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.