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
M4-20-0176-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 19, 2019

Response Submitted By
No response received

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."

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
August 19, 2018	Emergency Room Services	$12,566.95	$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) in Title 28, Part 2 of the Texas Administrative Code.

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

1. Did the insurance carrier respond to the request for medical fee dispute resolution (MFDR)?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. Texas Mutual Insurance Company acknowledged receipt of a copy of the MFDR request on September 27, 2019.

   28 Texas Administrative Code §133.307(d)(1) provides, if DWC does not receive a response within 14 calendar days of dispute notification, the dispute may be decided on the basis of the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

2. 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 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 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.

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 31, 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.