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
Metroplex Adventist Hospital

Respondents Name
Texas Mutual Insurance

MFDR Tracking Number
M4-20-0202-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to EOB received, bill for date of service September 20, 2018 was denied due timely filing. Please note that bill was submitted to BCBS of Texas prior to billing workers comp, and work comp insurance information was not obtained timely."

Amount in Dispute: $1,009.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim [claim number] and Metroplex Health Systems are participants in the WorkWell Network. Because this is network… …the requestor should access the Grievance Coordinator through WorkWell Tx."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
September 20, 2018	Outpatient hospital services	$1,009.81	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

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:
   - 29 – The time limit for filing has expired

Issue

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

Findings

The requestor is seeking reimbursement in the amount of $1,009.81 for outpatient hospital services rendered September 20, 2018. 28 TAC §133.307(c)(1) states a request for medical fee dispute resolution that does not involve issues of 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 September 20, 2018. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 23, 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 above.

DWC concludes that the requestor has failed to timely file this dispute with DWC's MDR Section and has waived the right to medical fee dispute resolution.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This finding is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that this dispute is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

FINDINGS

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not eligible for Medical Fee Dispute Resolution under 28 Texas Administrative Code §133.307.

Authorized Signature

		November 7, 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, 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 (**DWC-045M**) 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 the Division. **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).