



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Baylor Surgical Hospital

Respondent Name

American Casualty Co of Reading PA

MFDR Tracking Number

M4-20-0291-01

Carrier's Austin Representative

Box Number 57

MFDR Date Received

October 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to EOB received bill for date of service 9/25/18 was denied unrelated based on extent of injury. Please note that patient received medical treatment relating to back injury due to lifting heavy boxes at work."

Amount in Dispute: \$815.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...Date of service for 9/25/18 is not to be considered by the Division as the request for MDR is untimely."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2018	Outpatient hospital services	\$815.34	\$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.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 219 – Based on extent of injury

Issue

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

Findings

The requestor is seeking reimbursement for outpatient hospital services rendered September 25, 2018. The insurance carrier denied the medical bill based on extent of injury.

28 TAC §133.307(c)(1) states a request for medical fee dispute resolution that involves issues of compensability, or extent of injury, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability.

The date of the service in dispute is September 25, 2018. The decision from the Administrative Law Judge was November 26, 2018. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 1, 2019.

This date is later than 60 days of the final decision of the ALJ.

DWC concludes that the requestor has failed to timely file this dispute with DWC’s MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC 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 payment is due. As a result, the amount ordered is \$0.00.

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

Signature	Medical Fee Dispute Resolution Officer	November 20, 2019 Date
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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 **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.