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
Rollins Brook Community Hospital

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-20-0384-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB received, bill for date of service 12/31/17 was denied due to timely filing. Please note that we previously billed BCBS, and proof of timely filing is enclosed for review."

Amount in Dispute: $4,852.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed its claim file and found (B) (i-iii) do not apply."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 31, 2017	Outpatient hospital services	$4,852.82	$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

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 of outpatient hospital services rendered on December 31, 2017. The insurance carrier denied the services due to untimely submission of the claims.

28 TAC §133.307(c)(1) states a request for medical fee dispute resolution that does not involve an issue 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 December 31, 2017. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 11, 2019.

This date is later than one year after the date(s) of service in dispute.

Review of the submitted documentation found insufficient evidence to support any of the issues identified above.

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

		November 21, 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 **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.