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
METHODIST DALLAS MEDICAL CENTER

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-2165-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 04, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per my conversation with Jazmine at Texas Mutual on 4/29/20 at 9:27 a.m., (C/ref # Jazmine O, 4/29/20, 9:46 a.m. CST), she stated the 1st level appeal was received on 2/11/20 and a determination made to deny the appeal due to it was the 10 month filing deadline. She stated I could file a 2nd level appeal with you. Please review the documentation that is enclosed and accept this letter as a formal 2nd level appeal and request for payment."

Amount in Dispute: $34,257.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from disputed date 6/4 to 6/6/2018 is 6/4 to 6/6/2019. The TDI/DWC date stamped lists the received date as on the requestor's DWC-60 packet, a date greater than one year from 6/4 to 6/6/2018 ."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2018	Hospital Outpatient	$34,257.53	$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:
    - CAC-P12 Workers Compensation Jurisdictional fee schedule adjustment
    - CAC-W3 In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for

reconsideration or appeal

- CAC-138 Appeal procedure not following or time limits not met
- CAC-193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- CAC-243 Services not authorized by network/primary care providers
- CAC-97 The benefit for this services included in the value of another procedure that has already been adjudicated
- 217 The value of this procedure is included in the value of another procedure performed on this date
- 305 The implant is included in this billing and is reimbursed at the higher percentage calculation
- 350 Bill has been identified as a request for reconsideration or appeal
- 616 – This code has a Status Q APC indicator and is packaged in to other APC codes that have been identified by CMS
- 724 No additional payment after a reconsideration of services. For information call 800-937-6824
- 727 Provider not approved to treat Texas Star Network claimant. For network information call 800-831-8067
- 879 – Rule 133.250(B) – Health care provider shall submit the request for reconsideration no later than 10 months from the date of service
- CAC 18 – Exact duplicate claim/service
- CAC-272 Coverage/program guidelines were not met
- 736 – Duplicate appeal. Network contract applied by Texas Star Network. Call 800-381-8067 for reconsideration
- 757 – Network reductions based on Focus Healthcare contract. For questions regarding network reductions call 1-800-243-2336
- 879 – Rule 133.250(B) Health care provider shall submit the request for reconsideration no later than 10 month from the date of service

Issues

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

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

> Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
>
> (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is June 04, 2018 to June 6, 2018. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 04, 2020. 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 in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement 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, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

_____

Signature

Medical Fee Dispute Resolution Officer

May 29, 2020
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 Texas Administrative Code §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR 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 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.