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
Tarrant County Hospital District

Respondent Name
FCCI Insurance Company

MFDR Tracking Number
M4-20-2396-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
June 3, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a 4 day inpatient stay that should pay per IPPS per TDI rule 134.404."

Amount in Dispute: $26,885.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As the requester, Tarrant County has the burden to prove that it is entitled to additional reimbursement. Tarrant County failed to provide any reasoning why it is entitled to additional reimbursement. Other than submitting billing information, Tarrant County has failed to explain why the reimbursement paid by FCCI is insufficient or how, under the applicable guidelines, Tarrant County is entitled to additional reimbursement."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
DWC 060 shows November 14 – 18, 2019 Medical bill and EOBs show March 28 – April 1, 2019	Inpatient Hospital Services	$26,885.29	$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. 28 Texas Administrative Code §133.260 sets out requirements of a refund request.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
   - Workers Compensation jurisdictional fee schedule adjustment

Issue

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

Findings

28 TAC §133.307(c)(1) states a requestor shall request medical fee dispute no later than one year after the date(s) of service in dispute unless the disputed service contains an issue of related compensability, extent of injury, liability medical necessity or a refund notice issued pursuant to a division audit or review.

The date of the service in dispute supported by the medical bill and explanation of benefits is March 28 through April 1, 2019. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 3, 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, subparagraph (B) or requirements of §133.260.

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

		July 6, 2020
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.