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
MHHS Hermann Hospital

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-21-0311-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 20, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Initially, MH Hermann Hospital submitted the claim to a wrong Carrier…."

Amount in Dispute: $50,847.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rationale given by the requestor for the late bill is not consistent with the Rule above, the provider has failed to submit proof of erroneous billing by other health care insurer to support timely filing."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13-14, 2019	Outpatient Hospital Services	$50,847.00	$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
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issue

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

Findings

The requestor is seeking reimbursement of outpatient hospital services rendered in September 2019. The insurance carrier denied the disputed services based on untimely submission of the medical bill. However, 28 TAC §133.307(c)(1) states in pertinent parts unless issues of compensability, extent of injury, liability, medical necessity or refunds requests for medical fee dispute shall be filed no later than one year after the date(s) of service in dispute.

The dates of the service in dispute is September 13 – 14, 2019. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 20, 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 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

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November , 2020
Signature	Medical Fee Dispute Resolution Officer	Date
		November 12 , 2020
Signature	Director of Medical Fee Dispute Resolution	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.