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 Orthopedic & Spine Hospital

Respondent Name
Tx Municipal League Intergovernmental Risk

MFDR Tracking Number
M4-21-0831-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 25, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In accordance with the TX WC fee schedule implants should be paid at manual cost + 10%."

Amount in Dispute: $41,125.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider failed to timely file its DWC-60 requesting Medical Fee Dispute Resolution."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2020	Outpatient Hospital Services	$41,125.37	$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:
   - 16 – Claim/service lacks information or has submission/billing error(s)
   - 227 – The report was not included with the billing. This charge will be evaluated upon receipt of the report
   - 252 – An attachment/other documentation is required to adjudicate this claim/service
   - 253 – In order to review this charge we will need a copy of the invoice
   - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – In accordance with the TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issue

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

Findings

The requestor is seeking reimbursement of outpatient hospital services rendered in January of 2020. The insurance company reduced the allowed amount based on lack of information. 28 TAC §133.307(c)(1) states in pertinent part a request for medical fee dispute that does not include issues of compensability, extent of injury, liability, medical necessity or a refund shall be filed no later than one year from the date of service in dispute.

The date of the service in dispute is January 6, 2020. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on January 25, 2021.

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

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. 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

		March 8, 2021
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.