



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

ST JOSEPH MEDICAL CENTER

Respondent Name

ZENITH INSURANCE COMPANY

MFDR Tracking Number

M4-21-1116-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 4, 2021

Response Submitted by:

The Zenith

REQUESTOR'S POSITION SUMMARY

"On behalf of St Joseph Medical Center, I am respectfully appealing the decision to deny payment for the above-mentioned claim. Per your determination, authorization was not obtained. We disagree with this determination. This was a medically necessary emergent encounter; therefore, authorization could not be obtained."

RESPONDENT'S POSITION SUMMARY

"Based on the review and findings above, no payment is due to the provider. Dr. Henry performed surgery without prior authorization. There is no indication by Dr. Henry that this surgery was emergent. The only comment on a 'medical emergency' is seen in the preauthorization request submitted by Dr. Henry's surgery scheduler, but this is merely a definition of what constitutes an emergency surgery, otherwise completely lacking clinical correlation to the request."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 21, 2020	Outpatient Facility Charges	\$11,979.47	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

Issues

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

Findings

- 1. The requestor seeks reimbursement for medical services rendered on February 21, 2020. 28 TAC §133.307(c) (1) states in pertinent part, "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 February 21, 2020. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 4, 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 in 28 TAC §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 TLC §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		March 26, 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 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 TAC §141.1(d).

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