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
BAYLOR ORTHOPEDIC & SPINE HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-1175-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 09, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB, bill partially paid due to the certification for implants not being signed. Please note implant invoices for this patient was in house. Documentation is also enclosed with a signed certification for implants. Please review and remit payment for remaining balance due."

Amount in Dispute: $11,544.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from disputed date is 2/14/2021. The TDI/DWC date stamp lists the received date as 3/9/2021 on the requestor's DWC-60 packet, a date greater than one year from 2/14/2020. The requestor has waived its right to DWC MDR.

No payment is due. "

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2020	Code C1713	$11,544.82	$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

- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions
- CAC-18 – Exact duplicate claim/service
- CAC-193 – Original payment decision is being maintained, upon review, it was determined that this claim was processed properly
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- DC4 – No additional reimbursement allowed after reconsideration. For information call (800) 859-5995 X3994
- DC7 – Duplicate appeal. Network contract applied by WorkWell Tx Network. Call (800) 859-595 X3994 for reconsideration discussion
- 350 – Bill has been identified as a request for reconsideration or appeal

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 February 14, 2020. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 09, 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 §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

[redacted]	[redacted]	April 01, 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 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.