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
South Texas Surgical Hospital

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-21-1176-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
March 11, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According TX workers compensation fee schedule the expected reimbursement for DOS 1/16/2020 is $13,024.64 which separate reimbursement was requested in Box 80 of UB-04 form for Rev code 278/implants."

Amount in Dispute: $1,876.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill for DOS 01/16/2020 will not be reviewed as this dispute has been submitted past the timely filing deadline per Rule 133.307..."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2020	Outpatient Hospital Services	$1,876.87	$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:
   - 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment

- 904 – In accordance with clinical based coding edits (National correct coding initiative/outpatient code editor), component code or comprehensive radiology services procedure (7000-79999) has been disallowed.
- 877 – Reimbursement is based on the contracted amount
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 4097 – Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider's charge

Issue

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

Findings

The requestor is seeking additional reimbursement for outpatient hospital services rendered in January 2020. 28 TAC §133.307(c)(1) states in pertinent part, a request for medical fee dispute resolution that does not involve issues of compensability, extent of injury, liability, medical necessity or a refund shall be filed no later than one year after the date(s) of service in dispute.

The date of the service in dispute is January 16, 2020. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on March 11, 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. 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

		March 29, 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.