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**
UT HEALTH TYLER

**Respondent Name**
STATE OFFICE OF RISK MANAGEMENT

**MFDR Tracking Number**
M4-21-1736-01

**Carrier's Austin Representative**
Box Number 45

**MFDR Date Received**
June 01, 2021

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We have appealed this billing several times and called the adjuster to find out what she is missing. She has not returned any phone calls. 5-13-2021 message left for the adjuster, 5-6-2021 message left for the adjuster, 4-20-2021 message left for the supervisor. We let them know the dx for [redacted] is not the primary dx, and to please reprocess the bill. We have sent medical records with each appeal 3/26/201 denied for a duplicate. 3/29/2021 denied for lack of medical records and the itemization which both were included. 4-26-2021 denied"

**Amount in Dispute:** $4,914.13

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Office performed an in-depth review of the dispute packet submitted by the UT Health Tyler and will respectfully request this medical fee dispute be dismissed due to it is not eligible for review pursuant to Rule §133.307 (c)(1) as the Division received this dispute on 6/7/2021 which is over 1 year from the date of service 5/28/20. Furthermore, the requesting provider is enrolled in our Careworks Texas HCN where the Division does not have jurisdiction on network determinations."

**Response Submitted by:** State Office of Risk Management

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 28, 2020 | Hospital Outpatient Service | $4,914.13 | $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 which is needed for adjudication. Remark codes whenever appropriate.
    - 251 – The attachment content received did not contain the content required to process this
    - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

**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 May 28, 2020. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 1, 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] | June 25, 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**.