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
HIGHLANDS REHAB HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-1911-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 28, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I would like to confirm this was received and accepted for review? Last one I submitted I received a letter in the mail stating it was received and the turnaround time, so I want to be sure. Thank you for your assistance in this matter."

Amount in Dispute: $508.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from dispute date is 4/18/20-4/30/2020. The TDI/DWC date stamp lists the received date as 6/28/2021 on the requestors DWC-60 packet, a date greater than one year. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2019 to April 30, 2019	Inpatient Hospital Service	$508.41	$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:
   - CO – Contractual obligation. The patient may not be billed for this amount
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claim attachment(s)/ other documentation. At least one

Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code this is not an ALERT.)

- 198 – Precertification/notification/authorization/pre-treatment exceeded
- L6 – Use this monetary amount for the internet paid on claim in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is I. Medicare Part A will provide code "IN" in PLB03-2

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 April 18, 2019 to April 30, 2019. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 28, 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]
Signature

[redacted]
Medical Fee Dispute Resolution Officer

July 23, 2021
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.