



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

DOCTORS HOSPITAL RENAISSANCE

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-22-0584-01

Carrier's Austin Representative

Box Number 45

DWC Date Received

November 23, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 3, 2020 through July 17, 2020	Outpatient Facility Services	\$1,546.34	\$0.00
Total		\$1,546.34	\$0.00

Requestor's Position

"Doctors Hospital at Renaissance is kindly requesting that the above claim be reprocessed and paid in accordance with Labor Code 408.0272 (2)(c)(1). Per your request attached you will find medical records along with the itemized bill, corrected UB and EOB for your review. Diagnoses have been corrected, attached therapy notes."

Amount in Dispute: \$1,546.34

Respondent's Position

"The Office performed an in-depth review of the dispute packet submitted by the Doctor's Hospital at Renaissance and will maintain our original denials and respectfully request this medical fee dispute be dismissed due to it is not eligible for review pursuant to Rule §133.307 (c)(l) as the Division received this dispute on 11/23/2021 which is over 1 year from the date of service 7/17/2020."

Response Submitted by: SORM

Findings and Decision

Authority

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

Statutes and Rules

28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced or denied the 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 CLAIM OR SERVICE.
- 4 - THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
- 29 - THE TIME LIMIT FOR FILING HAS EXPIRED.
- NOTE:THE PROVIDER HAS RESUBMITTED THIS BILL. BUT HAS REMOVED/CHANGED THE DIAGNOSIS CODE, CPT/HCPC CODE(S), MODIFIER, POS AND/OR TOTAL BILL CHARGE AMOUNT, THUS MAKING IT A NEW BILL & SUBJECT TO THE 95 DAY TIMELY FILING RULE.

Issues

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

Findings

The requestor seeks reimbursement for medical services rendered on July 3, 2020 through July 17, 2020.

Per 28 TAC §133.307(c) (1), "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 dates of the services in dispute are July 3, 2020 through July 17, 2020. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 23, 2021. These dates are later than one year after the dates 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

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement of is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		December 17, 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must 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** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.