

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

VHS HARLINGEN
HOSPITAL

Respondent Name

SWISS REINSURANCE AMERICA CORP

MFDR Tracking Number

M4-23-0607-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

November 08, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 27, 2021	Code C1767 and 63685	\$51,637.73	\$0.00
	Total	\$51,637.73	\$0.00

Requestor's Position

Requestor did not provide a position statement.

Amount in Dispute: \$51,637.73

Respondent's Position

Moreover, a provider's request for medial fee dispute resolution was required to be filed with the medical Division no later than one year following the date of service. See Division Rule 133.307(c)(1)(A) .

Response Submitted by: Flahive Ogden & Latson

Findings and Decision

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

1. 28 Texas Administrative Code (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:

- 29 – The time limit for filing has expired
- 4271 – Per TX Labor Code Sec 408.0827, providers must submit bills to payors within 95 days of the date of service

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 must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division 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 27, 2021. The request for medical fee dispute resolution was received on November 8, 2022. 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; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

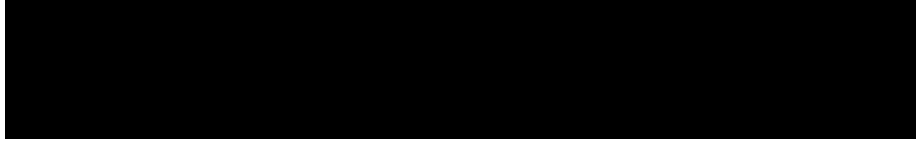
The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds that no additional reimbursement 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 9, 2022

Signature

Medical Fee Dispute Resolution Officer

Date



December 9, 2022

Signature

Director of Medical Fee Dispute Resolution 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 electrónico CompConnection@tdi.texas.gov.