



# Texas Department of Insurance

## Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Baylor Ortho and Spine Hosp

**Respondent Name**

Hartford Insurance Company

**MFDR Tracking Number**

M4-12-3642-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

August 21, 2012

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We never received a payment, the carrier confirmed receipt and stated payment was issued on 10/17/11 in the amount of \$6542.03 check# 30222658 however the address the payment was forwarded to was incorrect, PO BOX 843909, Arlington, TX 76015. We have contacted the carrier on multiple occasions to request a stop pay and reissue and we were not successful, as there was nothing to appeal, but formally a lack of acknowledgement a Reconsideration was not performed.

**Amount in Dispute:** \$4,150.38

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received however, no position statement submitted.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2011	Out patient hospital services	\$4,150.38	\$0.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 services in dispute have no explanation of benefits to indicate reason for reduction denial.

**Issue**

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

**Findings**

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box which was acknowledged received on August 21, 2012. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative

Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

2. 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 July 22, 2011. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on August 21, 2012. 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, subparagraph (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 Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

### ***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 services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

August 14, 2014  
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 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 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.**