



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Health Fort Worth

Respondent Name

Amerisure Insurance Co

MFDR Tracking Number

M4-18-5099-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

August 21, 2018

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3 – 9, 2017	Inpatient Hospital Services	\$10,739.96	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment denied/reduced for absence of precertification/preauthorization

Issue

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

Findings

28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.

(A) A request for medical fee dispute resolution 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.

(B) A request may be filed later than one year after the date(s) of service if:

- (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The date of the service in dispute is June 3 – 9, 2017. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on August 21, 2018. 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).

DWC concludes that the requestor has failed to timely file this dispute with the DWC's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

DWC 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 both 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, DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October 17, 2018
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 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.