



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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

AFFORDABLE HEARING CARE

Respondent Name

TEXAS WATER CONSERVATION ASSOC

MFDR Tracking Number

M4-11-0829-01

Carrier's Austin Representative

Box Number 43

MFDR Date Received

OCTOBER 29, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: \$1,345.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Not on file." "Carrier never received billing."

Response Submitted by: JI Specialty Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2005	CPT Code 92557	\$95.00	\$0.00
May 18, 2005 January 26, 2006	CPT Code 95267	\$35.00	\$0.00
May 18, 2005	CPT Code 92591	\$95.00	\$0.00
August 9, 2005 May 3, 2006 July 27, 2006 July 12, 2007 March 16, 2009 April 14, 2009 August 7, 2009 August 26, 2009 December 16, 2009 January 26, 2009 March 17, 2010 June 23, 2010	CPT Code 99201	\$45.00/date	\$0.00
August 12, 2009	HCPCS Code V5090	\$500.00	\$0.00
August 17, 2009	CPT Code 92593	\$45.00	\$0.00

TOTAL		\$1,345.00	\$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 health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29-The time limit for filing has expired.
 - W12-Extent of injury. Not finally adjudicated.
 - 5047-Per TWCC Rule, 134.801(C) a health care provider shall not submit a bill later than the first day of the 11th month after the date the services are provided.
 - W3-Additional payment made on appeal/reconsideration.

Issues

1. Does a compensability/extent and/or liability issue exist in this dispute?
2. Did the requestor waive the right to medical fee dispute resolution?
3. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent states in the position summary "The review shows that the original bill for date of service May 18, 2005 was received on May 11, 2006. An EOB was issued on May 31, 2006 denying the bill as not timely filed and extent of injury. Based on rule 134.801(c) A health care provider shall not submit a bill later than the first day of the 11th month after the date the services are provided. A request for reconsideration was received on July 21, 2009. The requestor for reconsideration, though received outside of TDI-DWC rule 133.250(c), was processed and allowed payment as the original bill had been incorrectly denied for extent." The Division finds that a compensability/extent and/or liability issue does not exist in this dispute.
2. 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." The dates of service in dispute are May 18, 2005 through June 23, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 29, 2010. Dates of service May 18, 2005 through August 26, 2009 are past the than one year filing deadline. 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 for dates of service May 18, 2005 through August 26, 2009 with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.
3. Former 28 Texas Administrative Code §133.307(c)(2)(A), requires that the request shall include "a copy of all medical bill(s) . . . as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration." Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the carrier and/or as submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).
 Former 28 Texas Administrative Code §133.307(c)(2)(B), requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed services. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).
 Former 28 Texas Administrative Code §133.307(c)(2)(C), requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." Review of the submitted documentation finds that the requestor has not completed the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the

Division. The requestor did not complete the columns under the headings Medical Fee Guideline MAR, Total Amount Paid, Amount in Dispute, and Requestor's Rationale for Increased Reimbursement or Refund. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under §133.307(c)(2)(C).

Former 28 Texas Administrative Code §133.307(c)(2)(E), requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records specific to the dates of service in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).

Former 28 Texas Administrative Code §133.307(c)(2)(F)(ii), requires that the request shall include a position statement including "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not explained the reasons that the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(ii).

The Division concludes that the request for medical fee dispute resolution was not filed in the form and manner required by 28 Texas Administrative Code §133.307?

4. As discussed above, the request for medical fee dispute resolution was submitted untimely for dates of service May 18, 2005 through August 26, 2009; dates of service December 16, 2009 through June 23, 2010 were missing required records to support requestor's position that reimbursement is due. As a result, no reimbursement is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish 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 services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

06/13/2014

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.