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 and Address

COMBINED CHIROPRACTIC SERVICES &
REHABILITATION INC
PO BOX 700311
SAN ANTONIO TX 78270

Respondent Name
INDEMNITY INSURANCE CO OF NORTH

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-12-2004-01

MFDR Date Received
February 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medical necessity established"

Amount in Dispute: $95.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor has not timely filed their request for medical dispute resolution in accordance with DWC Rule 133.307 (c) (1) (A). The date of service in dispute is 2/2/11, and Medical Fee Dispute Resolution received this dispute on 2/10/12, which is more than one year after the date of service. Respondent requests that this dispute be immediately dismissed based on Requestor's lack of timely filing."

Response Submitted by: Downs, Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 2011	99213	$95.00	$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:

Explanation of benefits dated

- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 216 – Based on the findings of a review organization.
- QA – The amount adjusted is due to bundling or unbundling of services.
- PI – These are adjustments initiated by the payer, for such reason as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patients responsibility, unless the workers compensation state law allows the patient to be billed.
- 18 – Duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.
- PI – Description not available.

Issue

1. 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."

The date of the services in dispute is February 2, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on February 10, 2012. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in 28 Texas Administrative Code §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR 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 both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 16, 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.