TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE NORTH DALLAS

Respondent Name
AMERICAN CASUALTY CO

MFDR Tracking Number
M4-13-0377

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reconsider this denial and remit payment for the meaning days..."

Amount in Dispute: $2,556.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed fees at issue described in the DWC-60 form submitted by Requestor should not be paid for the reasons stated on the EOBs and requests for reconsideration contained in the documents submitted by the Requestor."

Response Submitted by: Knott & Doyle

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2010 through March 16, 2012	99211-25, 99214-25, 99213-25 x 6, 97140-GP x 5, 97112-GP x 5, 97110-GP x 5 and 99080-73 x 3	$2,556.13	$0.00

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 §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.

Issues

1. Does the medical fee dispute referenced above contain information/documentation to support that the dispute contains **unresolved** issues of medical necessity for dates of service September 8, 2010 (CPT Code 99211-25) and 10/18/2010 through 3/16/2012?
2. Does the medical fee dispute referenced above contain information/documentation to support that the dispute contains **unresolved** issues of compensability/extent-of-injury and or liability (CEL) for date of service September 15, 2010?
3. Did the requestor waive the right to medical fee dispute resolution for dates of service September 8, 2010 through September 14, 2010?

Findings

1. Review of the submitted documentation finds that the medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for dates of service September 8, 2010 (CPT Code 99211-25) and 10/18/2010 through 3/16/2012.

   The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

   The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

   The Division finds that due to the unresolved medical necessity issues, the medical fee dispute request for dates of service September 8, 2010 (CPT Code 99211-25) and 10/18/2010 through 3/16/2012 are not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

   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. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that dates of service, September 8, 2010 (CPT Code 99211-25) and 10/18/2010 through 3/16/2012 are not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307 (f)(3)(B).

2. Review of the submitted documentation finds that the medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of extent of injury for date of service September 15, 2010. The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent-of-injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute for date of service September 15, 2010, may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

3. 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 dates of the services in dispute are September 8, 2010 through September 14, 2010. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on October 5, 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 dates of service September 8, 2010 through September 14, 2010 do not contain issues identified in §133.307(c)(1)(B). Although the disputed services were denied/reduced by the insurance with denial reason code "216 – Based on the findings of a review organization and W9-Unnecessary med treatment", the disputed services were preauthorized by the insurance carrier and therefore, do not contain unresolved issues of medical necessity. As a result, these dates of service do not involved issues identified in §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file dates of service September 8, 2010 through September 14, 2010 with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates.

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. This decision is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that reimbursement is not due.

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 disputed services.

Authorized Signature

		October 16, 2015
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.