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

ELITE HEALTHCARE FORT WORTH
PO BOX 1353
FRISCO TX 75034

Respondent Name
CROWLEY ISD

Carrier's Austin Representative
Box Number 43

MFDR Tracking Number
M4-14-0793-01

MFDR Date Received
November 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. Patient had authorization and was I the chronic pain program. Texas Behavorial Health was paid in full and our office has not been paid for any chronic pain claims. This has been sent in for reconsideration and still has been denied."

Amount in Dispute: $19,637.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The third party administrator (TPA) for Crowley ISD feels this request for MDR is filed way after the timely filing limits of TAC RULE 133.307(c)(1) and did not include all the components listed in §133.307(c)(2) and respectfully asks for the MFD to be dismissed as this HCP is non-compliant."

Response Submitted by: JI Specialty Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2010 through September 27, 2011	Office Visits Physical Therapy Chronic Pain Management Reports	$19,637.45	$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:
   - 18 – Duplicate claim/service.
   - 247 – A payment or denial has already been recommended for this service.

- 219 – Based on extent of injury.
- 5053 – Treatment is not related to original work injury.

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 dates of the service in dispute are March 31, 2010 through February 22, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on November 8, 2013. 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 involve issues identified in §133.307, subparagraph (B). According to 28 Texas Administrative Code 133.307(c)(1)(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** (emphasis added). Review of the contested case hearing Decision and Order finds that the hearing was held on October 7, 2011 and signed by the hearing officer on October 12, 2011. The request for medical fee dispute resolution was received in the Division on November 8, 2013. 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.

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

Signature	Medical Fee Dispute Resolution Officer	February 28, 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.