



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE FORT WORTH

MFDR Tracking Number

M4-14-1095

MFDR Date Received

December 16, 2013

Respondent Name

ROCHDALE INSURANCE CO

Carrier's Austin Representative

Box Number 17

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient has had 11 visits to our office with 2 of those being paid in full. I do not have any documentation showing that claims should not be paid in full."

Amount in Dispute: \$1,030.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As a first response please note that this is misfiled by Requestor as a Fee Dispute. It is not a Fee Dispute as clearly indicated by the EOBs attached to its Request, as all EOBs clearly indicate that the bill has been denied in total based on Medical Necessity Dispute based on a peer review, a copy of Dr. Osborne's report attached hereto as Exhibit A. Requestor submits no documentation that it has ever gone through the required steps to submit a Medical Necessity Dispute by requesting an IRO, and in fact Carrier has not such requests from this health Care provider covering these dates."

Response Submitted by: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: May 22, 2012 through October 9, 2013; 99213 x 8, 99080-73, and 99361; \$1,030.32; \$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 §133.305 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. Did the requestor obtain preauthorization for the disputed services?
2. Does the medical fee dispute referenced above contain information/documentation that indicates that there are unresolved issues of medical necessity?
3. Are disputed dates of service, May 22, 2012 through September 11, 2012 and October 9, 2012 through October 9, 2013, eligible for review by Medical Fee Dispute Resolution?

Findings

1. The requestor seeks reimbursement for date of service September 21, 2012. 28 Texas Administrative Code §133.307(c) (2) (K), requires that the request shall include “a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB.” Review of the submitted documentation finds that the DWC060 request for date of service September 21, 2012, does not include copies of any EOBs for this service date. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (K). As a result, reimbursement cannot be recommended for date of service September 21, 2012.
2. The requestor seeks reimbursement for dates of service May 22, 2012 through September 11, 2012 and October 9, 2012 through October 9, 2013. Review of the EOBs submitted for review, 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 May 22, 2012 through September 11, 2012 and October 9, 2012 through October 9, 2013.
3. The Division hereby notifies the requestor that for dates of service, May 22, 2012 through September 11, 2012 and October 9, 2012 through October 9, 2013, 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 for dates of service May 22, 2012 through September 11, 2012 and October 9, 2012 through October 9, 2013 the dispute request is 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 this dispute is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

28 Texas Administrative Code §133.307(f) (3) states that a dismissal is not a final decision by the division. The requestor has the right to submit a new medical fee dispute after the medical necessity issue is resolved. The requestor is responsible for filing a medical fee dispute not later than 60 days after the date the requestor receives the final Division decision. The 60-day filing requirement described in 28 Texas Administrative Code §133.307(c)(1)(B)(i) replaces the one-year filing deadline in those cases where a final decision regarding medical necessity is made.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established 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 disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 22, 2015
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.