



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **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**

ACIG INSURANCE CO

#### **Carrier's Austin Representative**

Box Number 47

#### **MFDR Tracking Number**

M4-14-1437-01

#### **MFDR Date Received**

JANUARY 23, 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. These claims were sent in for reconsideration and were still denied. Patient had same exact services on 2.10.2012 and 7.27.2012; those both were paid in full. This date of service should be paid in full also..."

**Amount in Dispute:** \$113.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The insurance carrier or its agent did not submit a response to the request for medical fee dispute resolution.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2012	CPT Code 99361	\$113.00	\$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:
  - 97 – Charge included in another charge or service.
  - W1 – Case Management Services.
  - 18 – Duplicate claim/service
  - 193 – Original payment decision maintained.

## 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 service in dispute is March 19, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on January 23, 2014. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed service does involve issues identified in §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.

## **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.**