**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**
MSU HEALTHTEAM

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-14-1920-01

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Date Received**
FEBRUARY 28, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "At the end of July we received rejections from Texas work comp stating that the medical documentation didn't support the services that were billed… At this point we had charge corrections done to correct the information according to compliance and had the claims rebilled with the medical documentation on December 17th, 2013. Texas work comp then denied all the claims as over filing limit. These claims are adjusted claims that should be reviewed and processed accordingly for payment as we have worked diligently with the patient and the adjuster and texas [sic] work comp on getting these claims billed correctly."

**Amount in Dispute:** $432.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute. This disputed services for dates of service 4/2/2013 to 8/26/2013 have already been paid. (Attachment) No additional payment is due."

**Response Submitted by:** TEXAS MUTUAL INSURANCE CO

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 2, 2013<br>April 23, 2013<br>June 5, 2013<br>August 26, 2013 | Professional Services | $432.00 | $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 resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payer deems the information submitted does not support this level of service.
   - 16 – Claim/service lacks information which is needed for adjudication, at least one remark code must be provided.

- 29 – The time limit for filing has expired.
- 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service. For services on or after 9/1/05.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 724 – No additional payment after a reconsideration of services.
- 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems.

**Issues**

1. Did the requestor receive payment for the dates of service in dispute?
2. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Labor Code §133.307(f)(2) The division may raise issues in the MFDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and division rules. Review of the information submitted by the respondent finds payment has been made for the services in dispute; therefore a dispute no longer exists.
2. Because the respondent submitted EOBs showing payment was made additional reimbursement is not supported.

**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**

| | Marguerite Foster | November 21, 2014 |
|---|---|---|
| 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**.