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
ELITE HEALTHCARE NORTH DALLAS

Respondent Name
EMPLOYERS COMPENSATION INSURANCE

MFDR Tracking Number
M4-14-3121-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of service 6/14/11 – 2/29/12 were denied due to diagnosis. However, the patient went to a Contested Case Hearing that ruled Mild Carpal Tunnel Syndrome as compensable. Therefore, you are court ordered to pay these services in full. Also, date of service 8/24/11 was denied due to 'preauthorization' but per ODG Guidelines, preauthorization is not required for office visits, and are actually encouraged."

Amount in Dispute: $1,532.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Exceptions include issues of compensability, extent of injury, or medical necessity. In those situations, the MFDR request must be made no later than 60 days after the final decision on compensability, extent of injury, or medical necessity. The dates of service involved in this MFDR range from June 4, 2011 [sic] through June 20, 2012. The MFDR request was not filed until June 12, 2014, almost two years after the last date of service. The Requester argues that timeliness is overridden because there was an extent of injury issue. The extent of injury question was determined by CCH Decision and Order on March 26, 2012, prior to some of the dates of service in question."

Response Submitted by: Ricky D. Green, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2011 through June 20, 2012	99214, 99213, 99080 and 99213	$1,532.09	$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:
   - 214 – Workers' Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
   - 167 – This (these) diagnosis (es) is (are) not covered.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 50 – These are non-covered services because this is not deemed 'medical necessity' by the payer.
   - 216 – Based on the findings of review organization.
   - 3 – The service or diagnosis is not related to the covered injury or body part.
   - 1 – The compensability of this claim has been denied by the employer or payer.
   - 197 – Precertification/authorization/notification absent.
   - 1 – This service not authorized.

Issue

1. Did the requestor file the request with the division's MDR Section timely?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 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 June 14, 2011 through June 20, 2012. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 12, 2014. This date is later than one year after the date(s) of service in dispute.

2. 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."

   The requestor submitted a copy of a Contested Case Hearing dated March 26, 2012. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 12, 2014. This date is later than 60 days after the date the requestor received the final decision, inclusive of all appeals.

   The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR 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 the 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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 17, 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.