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
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-14-3181-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient won her contested case hearing on compensability on 1/8/10 and is court ordered to pay. The results of the hearing are attached. Therefore, the timely filing rule is over-rided [sic] since the denials are based on denied claim per Rule [sic] 410.208(a)(b). Per Rule [sic] 413.019, interest must be paid as well."

Amount in Dispute: $9,833.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 27, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2009 through July 28, 2011	99080, 99205, 97140, 97112, 97110, 99211, 99213, 99361, 99214, 97546 and 97545	$9,833.58	$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:
   - 001 – Payment has been denied by the claims administrator/adjuster $0.00.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 150 – Payer deems the information submitted does not support this level of service.
   - 003 CV – The E&M service documented does not meet the CPT requirements for modifier -25 services should not be billed separately $0.00.
   - 39 – Services denied at the time authorization/pre-certification was requested.
   - 18 – Duplicate claim/service.

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 September 1, 2009 through July 28, 2011. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 19, 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 January 12, 2010. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 19, 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.