



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

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-3224-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

JUNE 23, 2014

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2010 through July 12, 2010	Professional Services and Physical Therapy	\$2,205.25	\$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:
 - W1 – Workers Compensation State Fee Schedule adjustment.
 - 150 – Payer deems the information submitted does not support this level of service.
 - 16 – Claim/service lacks information which is needed for adjudication.
 - 47 – This (these) Diagnosis(es) is (are) not covered, missing, or are invalid
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
 - 890 – This level of service is being disputed as it does not meet the components as defined in the “CPT Book.”
 - 907 – Not all diagnoses submitted are related to the compensable injury. Only treatment rendered for the compensable injury is reimbursable.
 - 18 – Duplicate claim/service.
 - 224 – Duplicate charge.
 - 57 – Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
 - 864 – E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service.

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 dates of the service in dispute are February 3, 2010 through July 12, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 23, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not 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

		October 23, 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.