



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

LABORDE THERAPY CENTER  
KELLY ORTEGO, PT

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-14-3477-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

JULY 21, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "This letter is to address denials for date of service 1/8/13 CPT code 97002, stating that this code should not be billed along with another procedure code. I have included the notes which clearly indicates that both 97002 were done on this patient for a discharge eval. I have included explanation of each code for further review. Please review notes and reprocess this code."

**Amount in Dispute:** \$150.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The DWC060 is date stamped by the TDI/DWC on July 21, 2014. The date of service in question is 01/08/13. The requestor did not submit a request for medical dispute resolution within one year time limit required by DWC Rule 133.307(C)(1)(A); therefore this request should be denied."

**Response Submitted by:** AIG

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 8, 2013	CPT Code 97002 Physical Therapy Re-Evaluation	\$150.00	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
  - MX60-Per NCCI, the procedure code is denied, based on standard of medical, surgical practice. Procedure included in 97035.

**Issue**

1. 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 date of the services in dispute is January 8, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on July 21, 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(c)(1)(B). 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, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). 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	03/27/2015 Date
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**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.**