TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
YURY SLESS MD

MFDR Tracking Number
M4-15-0225-01

MFDR Date Received
September 16, 2014

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a rebuttal letter dated July 28, 2014 describing the connection between the current surgery and the initial date of injury. On September 03, 2014 we received a notice of determination from Texas Mutual indicating that our appeal had been denied and that a refund was still being requested... Please also note the letter of explanation that Dr. Sless provided to the insurance company, which is attached for your review."

Amount in Dispute: $1,594.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has not exhausted its administrative remedy prior to seeking medical fee dispute resolution. The only bill Texas Mutual has received is the one in the DWC060 packet. (Attachment) There is no evidence in Texas Mutual's claim file the requestor submitted a request for reconsideration. Such a request is prescribed by Rule 133.250. Texas Mutual urges DWC to dismiss the request."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2014	29822, 29826 and 64418	$1,594.65	$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. 28 Texas Administrative Code §133.260 sets out the refund guidelines.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 424 – Overpayment recoupment.
   - Note: Requesting recoupment as service rendered is not related to the compensable injury. Requesting recoupment in the amount of $1,424.65.
   - 195 – Refund issued to an erroneous priority Payer for this claim/service.
   - Note: Promptly remit the refund and a copy of this notification to the address above, attn: Medical Refunds.

Issues

1. Did the insurance carrier request a refund within the time allowed per 28 Texas Administrative Code §133.260(b)?
2. Did the requestor appeal the refund request?
3. Did the insurance carrier act on the health provider's appeal within 45 days after the date on which the health care provider filed the appeal?
4. Did the requestor remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal prior to the filing of MFDR?

Findings

1. 28 Texas Administrative Code §133.260(a) states in pertinent part "An insurance carrier shall request a refund with 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided"

   The requestor seeks resolution of an insurance carrier refund request for services rendered on May 15, 2014. On July 21, 2014, the insurance carrier requested a refund on an Explanation of Benefits (EOB, for CPT codes 29822, 29826 and 64418, for which it had reimbursed a total of $1,424.65. The Division finds that the insurance carrier met the requirements of 28 Texas Administrative Code §133.260(a).

2. Per 28 Texas Administrative Code §133.260 (b) "The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division. (c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by: (1) paying the requested amount; or (2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment."

   The insurance carrier issued an EOB dated July 21, 2014 requesting a refund for date of service May 15, 2014. The requestor responded to the refund request on July 28, 2014, stating, "Decision was based on a dispute to a 'subsequent' rupture of the left rotator cuff/shoulder, issued on 5/21/2014. Please be advised that there was no 'subsequent' rupture of the rotator cuff tendon." The Division finds that the requestor met the requirements of 28 Texas Administrative Code 133.260(b)(2) as the carrier made the request on July 21, 2014 and the appeal was made by the requestor on July 28, 2014, before the 45th day after receipt of the request for a refund.

3. Per 28 Texas Administrative Code §133.260(d) "The insurance carrier shall act on a health care provider's appeal within 45 days after the date on which the health care provider filed the appeal. The insurance carrier shall provide the health care provider with notice of its determination, either agreeing that no refund is due, or denying the appeal."

   Review of the submitted documentation supports that the insurance carrier acted on the health care provider's appeal on September 3, 2014. The Division finds that the insurance carrier met the 45-day timeframe requirement of §133.260(d).

4. Per 28 Texas Administrative Code §133.260(e) "If the insurance carrier denies the appeal, the health provider:
   (1) Shall remit the refund with any applicable interest with 45 days of receipt of notice of denied appeal; **and**
   (2) May request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution – General)."

   In this case, the requestor received substantive notice of the alleged overpayment on July 21, 2014. The requestor submitted insufficient documentation to support that a refund was remitted to the insurance carrier after the denial of the appeal and before the submission of the medical fee dispute. Review of the submitted documentation does not support that the requestor issued a refund to the insurance carrier as required by 28 Texas Administrative Code §133.260(e)(1). As a result, the Division finds that the refund request was submitted prematurely to Medical Fee Dispute Resolution by YS Orthopedics, PLLC.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the review of the refund request. The requestor has failed to establish that the dispute is eligible for review.

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 has failed to establish that the dispute is eligible for review.

Authorized Signature

		February 12, 2016
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 Division within twenty days of your receipt of this decision must receive the request. 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.