



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

TEXAS ALLIANCE MEDICAL GROUP

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-15-0454-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

OCTOBER 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary with the submitted DWC60.

Amount in Dispute: \$2,989.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the medical fee dispute resolution request from Texas Alliance Medical Group concerning the above referenced claim for dates of 8/26/11 to 4/5/13. The carrier asserts that as per Rule 133.307 (c)(1), the request for MFDR was not filed timely."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 26, 2011 Through April 5, 2013	Professional Services	\$2,989.00	\$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:
 - 863-022 – BASED ON FEE SCHEDULE GUIDELINES, BILLS SUBMITTED AFTER THE 95TH DAY AFTER THE DATE OF SERVICE ARE DISALLOWED.
 - B4 – Late filing penalty.
 - 080-001 – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT FOR THE ENTIRE BILL OF \$0.00.
 - 216 – Based on the findings of a review organization.
 - 910-053 – EXTENT OF INJURY, NOT FINALLY ADJUDICATED.
 - 94 – Processed in Excess of charges, \$0.00.

- 075-001 – 99080 THE ALLOWANCE FOR THIS CODE HAS BEEN INCLUDED IN THE ALLOWED AMOUNT IN EXPLANATION CODE 080-001.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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 dates of the services in dispute are 08/26/2011 through 04/05/2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on 10/1/2014. 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

Debra Hausenfluck
Medical Fee Dispute Resolution Officer

November 18, 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.