



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

ELITE HEALTHCARE FORTWORTH

Respondent Name

HARTFORD UNDERWRITERS INSURANCE CO

MFDR Tracking Number

M4-15-0988-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

November 24, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. All of this documentation was sent for reconsideration to the carrier and claim still denied. Patient has authorization for physical therapy. All other therapy has been paid for in full. Office visits are recommended as determined to be medically necessary. Carrier shall not withdraw a preauthorization or concurrent review approval once issued. Please see attached patient account statement showing all other claims being paid in a timely manner. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: \$310.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in response to the ongoing investigation on this claim file. We have carefully reviewed our file and offer the following in response to your inquiry:

- We received the original bill on 12/10/2012, under control number 0148158313 and paid \$310.75 on 12/18/2012, under check number 119346723
- We received a resubmission request on 04/15/2013, under control number 201035004 and zero paid the bill on 04/22/2013, advising the provider that the billing was paid correctly originally and this was a duplicate
- We received a resubmission request on 10/18/2014, under control number 204530785 and zero paid the bill on 10/22/2014, advising the provider that the billing was paid correctly originally and this was a duplicate."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 05, 2012	CPT Code 99213, 97112 and 97110	\$310.75	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 247 – A payment or denial has already been recommended for this service
 - B13 – Previously paid payment for this claim
 - 5359 – We are unable to process your re-billing as the documentation does not specify the concern regarding the original analysis. Please re-submit with a copy of the original EOR and a clarification for the basis of the reconsideration.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

In regards to the disputed filed mentioned above. The carrier response states "We received the original bill on 12/10/2012, under control number 0148158313 and paid \$310.75 on 12/18/2012, under check number 119346723", "We received a resubmission request on 04/15/2013, under control number 201035004 and zero paid the bill on 04/22/2013, advising the provider that the billing was paid correctly originally and this was a duplicate" and "We received a resubmission request on 10/18/2014, under control number 204530785 and zero paid the bill on 10/22/2014, advising the provider that the billing was paid correctly originally and this was a duplicate". There was contact with the provider to confirm if payment was received for the disputed services according to the insurance carrier response. However, there was no response received from the requestor.

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 December 05, 2012. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 24, 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

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

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

Signature

Medical Fee Dispute Resolution Officer

Date

5/22/15

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 MFDR 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.