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
Nueva Vida Behavioral Health and Associates

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-15-1447-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The date of service being denied for payment is 1/13/14 and 3/27/14. This date of service was performed within the authorized timeframe and was denied in error."

Amount in Dispute: $910.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per §133.307(c)(1)(A), a request for medical dispute resolution shall be filed no later than one year after the date of service in dispute. The TDI-DWC received date of January 15, 2015 is more than one year from date of service 01/13/2014. Therefore, this date is not eligible for dispute resolution. …Since the medical records dated 03/27/14, indicate a diagnosis of mood/ depressed and the pre-authorization was for evaluation of depression, this date was denied based on extent of injury."

Response Submitted by: Argus Services, 811 S. Central Expwy, Suite 440, Richardson, TX 75080

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2014 March 27, 2014	90791 90792	$910.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197A – Precertification/authorization/notification absent
   - 219 – Based on extent of injury
   - W3 – No reimbursement recommended on reconsideration.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?
2. Did the requestor resolve the extent of injury issues for date of service March 27, 2014?

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 13, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on January 15, 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.
2. The insurance carrier denied dates of service March 27, 2014 based on denial reason code "216 – Based on extent of injury," during the medical bill review process. The dates of service referenced above contain unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical bill review process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, dates of service March 27, 2014 were not considered in this review.

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	April , 2015 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.