



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 North Dallas

Respondent Name

Wal Mart Associates Inc

MFDR Tracking Number

M4-15-2011-01

Carrier's Austin Representative

Box Number 53

MFDR Date Received

March 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Office visits in conjunction with work status reports are required per TDI requirements, and office visits are recommended and encouraged per ODG guidelines.."

Amount in Dispute: \$969.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With respect to the dates of service 04-26-2012 and 08-16-2013 through 08-28-2013, this request for medical dispute resolution is not timely... Regarding the dates of service 04-07-2014 and 05-20-2014, there is an unresolved issue regarding the injured worker's extent of injury."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include dates from April 2012 to May 2014 and corresponding service numbers and amounts.

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. 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 5148 – Final action has been taken on this bill
  - 5081 – Reduction or denial of payment after reconsideration was completed
  - 50 – These are non-covered services because this is not deemed a medical necessity by the payer
  - 5059 – Based on the diagnosis. Treatment patterns and/or number of visits. The treatment exceeds our physician parameters.
  - W3 – Additional payment made on appeal/reconsideration
  - 193 – Original payment decision is being maintained
  - 197 – Payment denied/reduced for absence of precertification/authorization
  - W9 – Unnecessary medical treatment based on peer review
  - 219 – Based on extent of injury
  - 5073 – Charge unrelated to the compensable injury

### **Issues**

1. Did the requestor waive the right to medical fee dispute resolution?
2. Did the requestor resolve the dispute for work related illness or injury?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.

(A) A request for medical fee dispute resolution 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 April 26, 2012 and August 16 – 28, 2013. The request for medical fee dispute resolution was received in the Medical Dispute Resolution (MDR) Section on March 5, 2015. 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 MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

2. The insurance carrier denied dates of service April 7, 2014 and May 20, 2014 based on denial reason code "219 – 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 April 7, 2014 and May 20, 2014 are not eligible for medical fee dispute resolution.

3. The Division finds the services from April 26, 2012 and August 16 -28, 2013 were not filed timely to MFDR. The services from April 7, 2014 and May 20, 2014 have unresolved issues of extent and cannot be reviewed. No additional payment can be recommended.

**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	October 26, 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, 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.**