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
SETON MED CENTER WILLIAMSON

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-15-2397-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 03, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is supplemental to Part V of the attached form DWC-60, and will serve as SMCW (Seton Medical Center Williamson)'s "Requestor's Rationale for Increased Reimbursement or Refund." This dispute originated with ESIS's (hereinafter Carrier) denial of the above referenced claim based upon medical necessity. ESIS ORIGINALLY DENIED CHARGES UNRELATED TO THE COMPENSABLE INJURY. ATTACHED A DWC045 WAS SENT WITH WRONG DATE OF INJURY [date of injury] AND THEN CORRECTED WITH DATE OF INJURY [date of injury], THEN DENIED FOR NOT A APPROVED PROVIDER, [injured employee] WAS SEEN IN THE EMERGENCY ROOM, HOWEVER, PLEASE NOTE: AS THE MEDICAL REPORT SHOWS, THE PROCEDURES WERE MEDICALLY NECESSARY; THEREFORE, THE HOSPITAL HAS A RIGHT TO EXPECT REIMBURSEMENT … For these causes, the Requestor asks that Medical Fee Dispute Resolution issue a Findings and Decision that SMCW (Seton Medical Center Williamson) is entitled to reimbursement for the services discussed herein, as well as all fees, interest and any other relief to which SMCW (Seton Medical Center Williamson) may be justly entitled."

Amount in Dispute: $302.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Medical Fee Dispute Resolution received Requestor's DWC-60 on 4/3/15 as evidenced by the date stamp on the DWC-60. As the date of service in dispute is 8/5/13, Respondent requests Medical Fee Dispute Resolution enter a Findings and Decision stating Requestor waived their right to dispute resolution as the request was not filed within one year of the date of service."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 05, 2013	CPT Code J1855, J1170, J2550, 99283 and 96372	$302.16	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W12 – Charge unrelated to the compensable injury
   - 1 – Not approved provider
   - 2 – Treatment not authorized
   - 1 – Original DCN 20157889
   - 2 – Not approved provider

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Did the requestor file the disputed services in accordance with 28 Texas Administrative Code §133.305 and 133.307?

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 August 05, 2013. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 03, 2015. This date is later than one year after the date(s) of service in dispute. 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. Carrier denied the disputed service with denial code "W12 – Charge unrelated to the compensable injury."

   Per 28 Texas Administrative Code 133.305 (b) states "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   Per 28 Texas Administrative Code 133.307 (c)(1)(B)(i) states "a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability."

   Review of the submitted documentation provided by the requestor finds there is an unresolved extent of injury for the same service for which there is a medical fee dispute.

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.

Even though all the evidence timely presented to the medical fee dispute program by the parties was not discussed, it was considered.

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

		5/15/15
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 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.