



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

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-15-2631-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

April 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dates of services 3/4/10, 3/11/10, and 3/17/10 were denied incorrectly. See attached Rule 134.204e. The denial states per I.M.E., yet we never received a copy of it ...

Dates of services 1/15/13, 1/17/13, 1/18/13, 1/22/13 and 1/24/13 (along with corrected pricing for numerous other dates that were paid in full) were all submitted with the CORRECTED PRICING per the Fee Schedule update TIMELY on 3/17/13, 7/18/13, 10/28/13, 11/14/13. See attached fax confirmations per Rule 133.20b

Amount in Dispute: \$448.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a Network claim

Date of service listed in the MDR Docket number m4-15-2631-01 regarding medical necessity for an office visit, team conference and physical therapy evaluation must go thru the IRO process."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include service dates from March 2010 to January 2013 with corresponding CPT codes and amounts.

January 22, 2013 through January 24, 2013	CPT Code 97112	\$1.36	\$0.00
February 20, 2013	CPT Code 97002	\$69.18	\$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. 28 Texas Administrative Code §133.305 sets out the general medical provisions.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - X591 – Per Independent medical exam, this treatment is not medically necessary. For Texas Jurisdiction claims only, per Texas Labor Code Section 413.031 and 28 TEX. ADMIN Code Sections 133.308(H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC appointed independent review organization. The form to initiate this process can be obtained from the division website at WWW.TDI.STATE.TX.US
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - Z559 – Reimbursement has paid in accordance to the Texas Division of Worker Compensation Rules, Chapter 129 Rule 129.5(A)-(J)
 - Z469 – Procedure is reimbursable when requested by carrier on self-insured employer
 - W3 – Additional payment made on appeal/reconsideration

Issues

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

Findings

1. 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.

The insurance carrier denied disputed service with denial code "X591 – Per Independent medical exam, this treatment is not medically necessary. For Texas Jurisdiction claims only, per Texas Labor Code Section 413.031 and 28 TEX. ADMIN Code Sections 133.308(H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC appointed independent review organization. The form to initiate this process can be obtained from the division website at WWW.TDI.STATE.TX.US." Review of the submitted documentation finds the disputed services have unresolved issues identified in 28 Texas Administrative Code §133.305(b). Therefore, no reimbursement is due.

2. 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 March 4, 2010 through March 11, 2010, March 17, 2010, January 15, 2013, January 17, 2013, January 18, 2013, January 22, 2013 through January 24, 2013 and February 20, 2013 . The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 20, 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 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

6/12/15
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.