



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS BONE & JOINT CENTER

Respondent Name

AMERISURE MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-3183-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

May 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Amerisure denied CPT code 99442 missing modifier, Please review corrected claim adding W1 modifier to case management and attached documentation for reprocessing of reconsideration for payment."

Amount in Dispute: \$125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In response to the above-mentioned dispute, please note, this is a Texas In-Network Claim and is not subject to MDR. MFDR has not been filed in a timely manner per rule 133.307 MDR of Fee Disputes. The HCP has not filed a request for reconsideration per rule 133.250. Texas Bone & Joint Center submitted a new billing by adding modifier W1 to original CPT code.

Both bills have been processed per Rule 134.204 Medical Fee Guideline for Workers' Compensation Specific Services. The HCP billed procedure code 99442 for Phone, E/M. Per Rule 134.204 specific CPT Codes are required, 99371, 99372, 99373.

MCMC LLC placed a note on the EOR referring the HCP to the specific rule. No additional reimbursement is recommended."

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 19, 2013, CPT Code 99442, \$125.00, \$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:
 - 16 – Claim/service lacks information which is needed for adjudication. Remark Codes whenever appropriate

Issues

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

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 December 19, 2013. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 28, 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	Date
		6/16/15

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.