



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

DJO LLC

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-3425-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a claim for the above member. We believe that the necessary medical criterion has been met. Please review the attached information and reconsider your original determination. If we have attached a copy of your Medical Policy, please reference the highlighted portions."

Amount in Dispute: \$4,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 6/9/14. Texas Mutual preauthorized an external bone growth stimulator to be provided to the claimant between 4/30/14 and 5/30/14 per the preauthorization approval letter. (See DWC60 packet). The requestor provided it on 6/9/14. Texas Mutual declined to issue payment to the requestor absent preauthorization. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|--------------------|-------------------|------------|
| June 09, 2014 | CPT Code E0747- NU | \$4,200.00 | \$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804. THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL

- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED

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 June 09, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 15, 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

7/10/15
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.