



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

KIRIT C SHAH MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-3427-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed is the copy of our claim and the denial EOBs that we received from Texas Mutual and Coventry on patient [injured employee], for the services provided by Dr. Shah on 5/2/2014. Please register that this the patient was a trauma case and the emergency neurosurgery was performed by Dr. Lapsiwala on 5/2/2014 at Harris Hospital. Dr. Shah performed Intraoperative Neurophysiological Monitoring during the entire surgery with Dr. Lapsiwala. Dr. Shah was on call at Harris Hospital for Intraoperative Monitoring that whole week. The Harris Hospital billing department had called the insurance company and was informed that the authorization was not required. (Please see the copy of the attached Face Sheet from Harris Hospital.) Please note, that the billing representative from Harris Hospital was misguided by Texas Mutual. Once again, please register that this was a trauma case and the surgery was performed on an emergency basis."

Amount in Dispute: \$3,825.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance Company received a TWCC-60 from the above mentioned requester. Pursuant to Commission Rule 133.307(d) Texas Mutual files the attached, completed response, and related items.

The following is the carrier's statement with respect to this dispute 5/2/2014.

- 3. One year from disputed date 5/2/14 is 5/2/15. The TDI/DWC date stamp lists the received date as 6/15/15 on the requestor's DWC-60 packet, a date greater than one year from 5/2/14. The requestor has waived its right to DWC MDR.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: May 02, 2014, CPT Codes 95886, 95908, 95937, 95938, 95939 and 95940, \$3,825.00, \$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:
  - 197 – Precertification/authorization/notification absent
  - 785 – Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service
  - 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
  - CAC-197 – Precertification/authorization/notification absent

### **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.
- (B) A request may be filed later than one year after the date(s) of service if:
  - (i) 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;
  - (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity

The date of the service in dispute is May 02, 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

8/4/15  
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.**