



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 FORT WORTH

Respondent Name

FARMINGTON CASUALTY CO

MFDR Tracking Number

M4-15-4037-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

August 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am submitting claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. Patient has authorization for physical therapy in our office. Patient was approved for 2 units 97140, 2 units 97112 and 4 units 97110. Carrier did not pay accordingly to the authorization. I have sent this in as a reconsideration to the carrier on 4.28.2015 and didn't received the difference of payment."

Amount in Dispute: \$801.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "THIS REQUEST FOR MEDICAL FEE DISPUTE RESOLUTION SHOULD BE DISMISSED UNDER RULE 133.307(f)(3)(D) AS THE PROVIDER FAILED TO TIMELY FILE THIS REQUEST WITHIN ONE YEAR OF THE DATE OF SERVICE IN ACCORDANCE WITH RULE 133.307(c)(1) ...

This Request for Medical Fee Dispute Resolution should be dismissed under Rule 133.307(f)(3)(D) as the Provider failed to timely file this Request within one year for the date of service in accordance with Rule 133.307(c)(1). The dates of service at issue run until 11-04-2013. As evidenced by the Division date stamp, this Request was filed 08-13-2015, or 282 days late. Therefore, the Request for Medical Fee Dispute Resolution should be dismissed as untimely."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2013 to September 30, 2013	CPT Code 97140 and 97110	\$801.66	\$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:
 - 168 – exceeds daily maximum pt allowance
 - 247 – duplicative service
 - B13 – previously paid. Payment for this claim/service may have been provided in a previous payment
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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 August 22, 2013 to September 30, 2013. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on August 13, 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
		09/01/15

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.