



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

DOWNTOWN PERFORMANCE
MEDICAL

Respondent Name

INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number

M4-16-0024-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 03, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting assistance from your office on the above - mentioned patient for services rendered on 08/26/2014. We initially submitted this claim on September 22, 2014 and the reconsideration was submitted on November 20, 2014. These services were denied for the following reason:

- (16) Claim/service lacks information of has submission/billing error(s) which is needed for adjudication
The provider's State Billing License Number is invalid or was not received pursuant to Texas Rule 133.10. The billing provider shall enter the "OB" qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'). Please resubmit bill with this information included. (F262)
Workers' Compensation Medical Treatment Guideline adjustment
No additional reimbursement allowed after review of appeal/reconsideration."

Amount in Dispute: \$1,189.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position for date of service 08/26/2014 was not file timely. Rule 133.307 (c)(1)(A), state a request for MFD that does not involve issues identified in subparagraph (B) of this shall be filed no later than one year after the date(s) of service in question. This claim did not involve any extent of injury, compensability or liability disputes to this date of service; therefore this medical fee dispute should be dismissed on the grounds that it was not filed timely per the Statue."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 26, 2014, CPT Code 97750, \$1,189.44, \$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:
  - 1 (16) – Claim/service lacks information has submission/billing error(s) which is needed for adjudication
  - 1 – The provider's State Billing License Number is invalid or was not received pursuant to Texas Rule 133.10. The billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX') Please resubmit bill with this information included (F262)
  - 1 – Workers' Compensation Medical Treatment Guideline Adjustment
  - 6 – No additional reimbursement allowed after review of appeal/reconsideration

### **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 26, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 03, 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
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10/2/15

## ***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.**