



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

EAST TEXAS INFECTIOUS DISEASE

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-16-0155-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Requestor did not provide a position statement with its DWC-60 request.

Amount in Dispute: \$1,618.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DOS 7/19/14-7/15/14 \$1401.21 (DCN 2015079F4020024):

- Originally denied as: This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information
It has been determined that the state of Texas allows billing of Home Health services on either HCFA or UB billing form
Please note, two of the submitted codes for DOS 7/9/14 were originally received for different amounts:
ON DCN 2015079F4020024 - (J2543-\$17.21 & A4305-\$36.00) ...

The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control."

Response Submitted by: Flahive Ogden & Latson PO Box 201329 Austin TX 78720

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 09, 2014 to July 15, 2014, CPT Code J2543, A4305 and J2543, \$1,618.07, \$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 or has submission/billing error(s) which is needed for adjudication
 - BL – To avoid duplicate bill denial. For all recon/adjustments/additional pymt requests, submit a copy of this EOR or Clear notation that a rec

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 July 09, 2014 to July 15, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 18, 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
		10/16/15

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.