



# 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**

JUAN HERNANDEZ

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-16-0452-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

October 20, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The above claim has been denied due to timely filing. However, this claim was originally sent within the timely filing limits. Please see attached claims report, stating that this claim was originally sent (electronically/paper) to the correct insurance company on (09/05/14). This date was within the timely filing limits and the claim should have been paid upon receipt. It has been incorrectly denied due to timely filing."

**Amount in Dispute:** \$105.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute 08/25/14 ... One year from disputed date 8/25/2014 is 8/25/2015. The TDI/DWC date stamp lists the received date as 10/20/2015 on the requestor's DWC-60 packet, a date greater than one year from 8/25/2015. The requestor has waived its right to DWC MDR."

**Response Submitted by:** Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2014	CPT Code 87252	\$105.00	\$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-18 – Exact duplicate claim/service

- CAC-29 – The time limit for filing has expired
- 716 – A denial was made because a different provider has billed for the services
- 731 – Per 133.20(B) Provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- CAC-138 – Appeal procedure not followed or time limits not met
- CAC-16 – Claim/service lacks information or has submission/billing error(S). Which is needed for adjudication
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824
- 879 – Rule 133.250(B) – Health care provider shall submit the request for reconsideration for reconsideration no later than 10 months from the date of service
- CAC-P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
- CAC-45 – Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 729 – This bill was reviewed in accordance with your first health contract. For questions please call 1-800-937-6824
- 790 – This charge was reimbursed. In accordance to the Texas Medical Fee Guideline

### **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 25, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 20, 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

11/12/15

**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.**