



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 FORTH WORTH

Respondent Name

CITY OF FORT WORTH

MFDR Tracking Number

M4-16-0467-01

Carrier's Austin Representative

Box Number 04

MFDR Date Received

October 22, 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. These are ridiculous denials for this patient. Carrier had paid same services for this patient on 3.14.2014. All healthcare professionals participating in the conference ARE NOT employees of the treating provider. They are EMPLOYEES OF ELITE HEALTHCARE FORTH WORTH. Same as the treating provider he also in an EMPLOYEE OF ELITE HEALTHCRE FORT WORTH. Patient also won their CONTESTED CASE HEARING, please see attached decision and order SIGNED BY A JUDGE stating that all claims are to be paid in full along with INTEREST."

Amount in Dispute: \$339.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in regards to the Medical Dispute Request from Elite Healthcare Fort Worth for services on 05/23/2014-09/19/2014. After review of the bill in question, our recommendation is to agree with the denial of the previous audits per Rule 134.204(e)(1)(A) as team members shall not be employees of the treating doctor ...

Date of service of 5/23/2014 was processed by Corvel and denied with CARC codes 219 – Based on Extent of Injury and W3 – Appeal/Reconsideration on 12/9/2014. The bill was denied with CARC codes of 193 – Original payment decision is maintained, 234 – This procedure is not paid separately, W3 – Appeal/Reconsideration. This bill was finalized on 8/10/2015.

Date of service of 8/15/2014 was processed by Corvel and denied with CARC codes of 234 – This procedure is not paid separately while referencing rule 134.204 (e)(1)(A) as team members shall not be employees of the treating doctor and W3 – Appeal/Reconsideration. This bill was finalized on 12/2/2014. The bill was processed as a reconsideration again on 7/31/2015. The bill was denied with the CARC codes of 193 – Original payment decision is maintained, 234 – This procedure is not paid separately, W3 – Appeal/Reconsideration. This bill was finalized on 7/31/2015.

Date of service of 9/19/2014 was processed by Corvel and denied with CARC codes of 234 – This procedure is not paid separately while referencing rule 134.204 (e)(1)(A) as team members shall not be employees of the treating doctor and W3 – Appeal/Reconsideration. This bill was finalized on 12/16/2014. The bill was processed as a reconsideration again on 8/3/2015 and denied the charges referencing rule 134.204(e)(1)(A) as team members shall not be employees of the treating doctor. The bill was denied with CARC codes of 193 – Original

payment decision is maintained, 234 – This procedure is not paid separately, W3 – Appeal/Reconsideration. This bill was finalized on 8/3/2015. .”

Response Submitted by: WellComp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2014	CPT Code 99361	\$339.00	\$0.00
August 15, 2014			
September 19, 2014			

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:
 - 219 – Based on extent of injury
 - W3 – Appeal/Reconsideration
 - W1 – Case management Services
 - 193 – Original payment decision maintained
 - 234 – This procedure is not paid separately

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 May 23, 2014; August 15, 2014 and September 19, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 22, 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

		12/3/15
Signature	Medical Fee Dispute Resolution Officer	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.