



# 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**

MATTHEW J TROVATO MD PA

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-16-0866-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

December 01, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We are requesting a review of the attached claim for Dr. Matthew Trovato. Claim was denied for timely. However, this claim was initially filed on December 18, 2013, which is well within 95 days from the date of service.

For your reference to process claim correctly we are attaching both a system ledger showing that original file date, as well as the claim form with a file date of 12/18/13 in Box 31."

**Amount in Dispute:** \$51,550.81

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute 11/18/2013 to 11/18/2013 ...

One year from disputed date 11/18/13 is 11/18/14. The TDI/DWC date stamp lists the received date as 12/1/15 on the requestor's DWC-60 packet, a date greater than one year from 11/18/13. The requestor has waived its right to DWC MDR. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Company 6210 E Hwy 290 Austin TX 78723

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2013	CPT Code 13132, 13133, 25260, 26418, 64856 and 69990	\$51,550.81	\$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.

2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- CAC-29 – The time limit for filing has expired
  - 731 – Per 133.20 provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date of the service, for services on or after 9/1/05
  - CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
  - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
  - 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 reconsideration of services. Information call 1-800-937-6824

**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 November 18, 2013. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on December 01, 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	12/18/15 Date
-----------	--	------------------

Signature	Medical Fee Dispute Resolution Manager	12/18/15 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.**